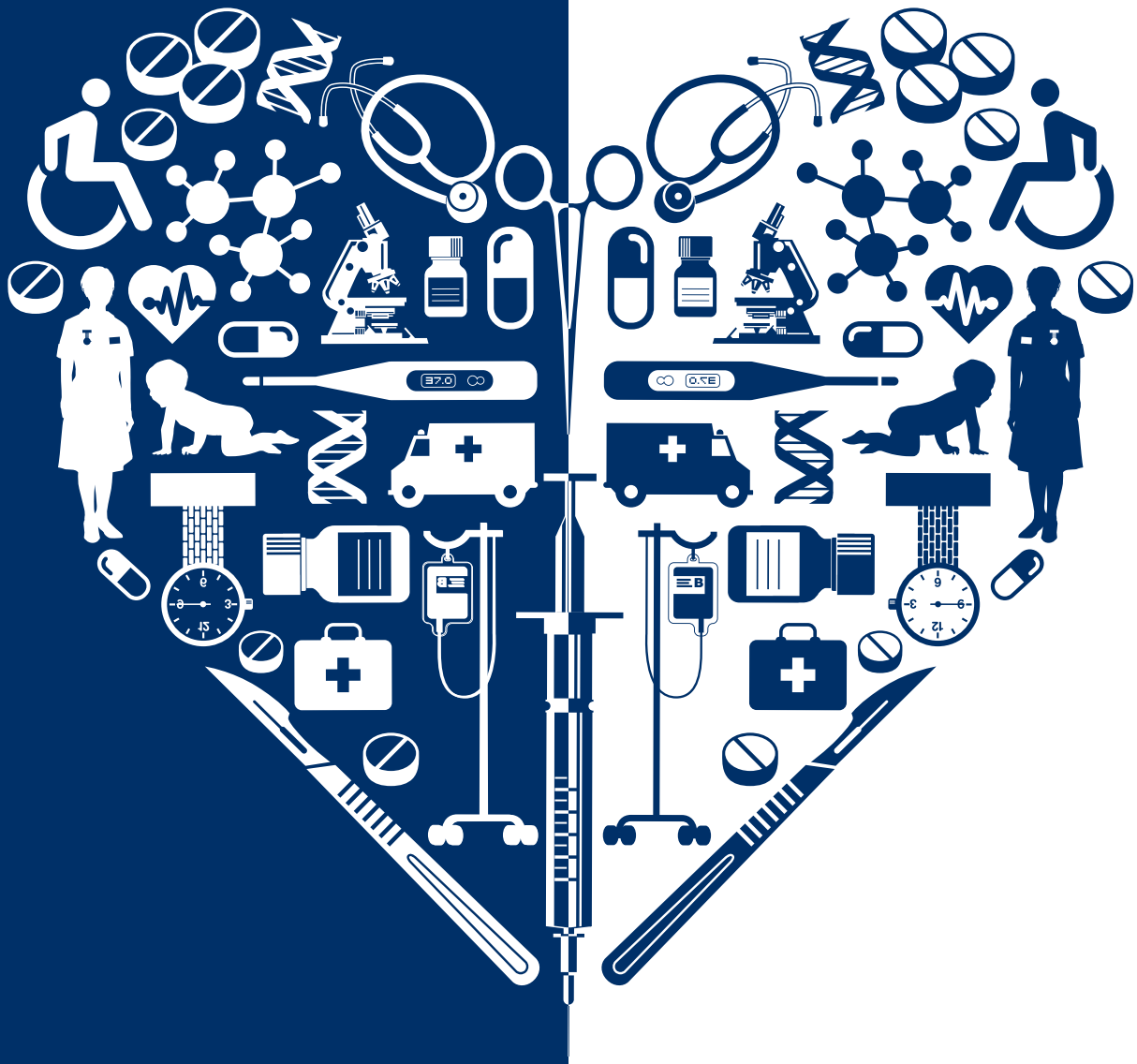
LUTON & DUNSTABLE UNIVERSITY HOSPITAL



Annual Report and Accounts

for the period April 2015 to March 2016
incorporating Quality Account

Luton and Dunstable University Hospital
NHS Foundation Trust

NHS

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NHS Foundation Trust

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Presented to Parliament pursuant to Schedule 7, paragraph 25 (4) (a) of the National Health Service Act 2006

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LUTON AND DUNSTABLE UNIVERSITY HOSPITAL

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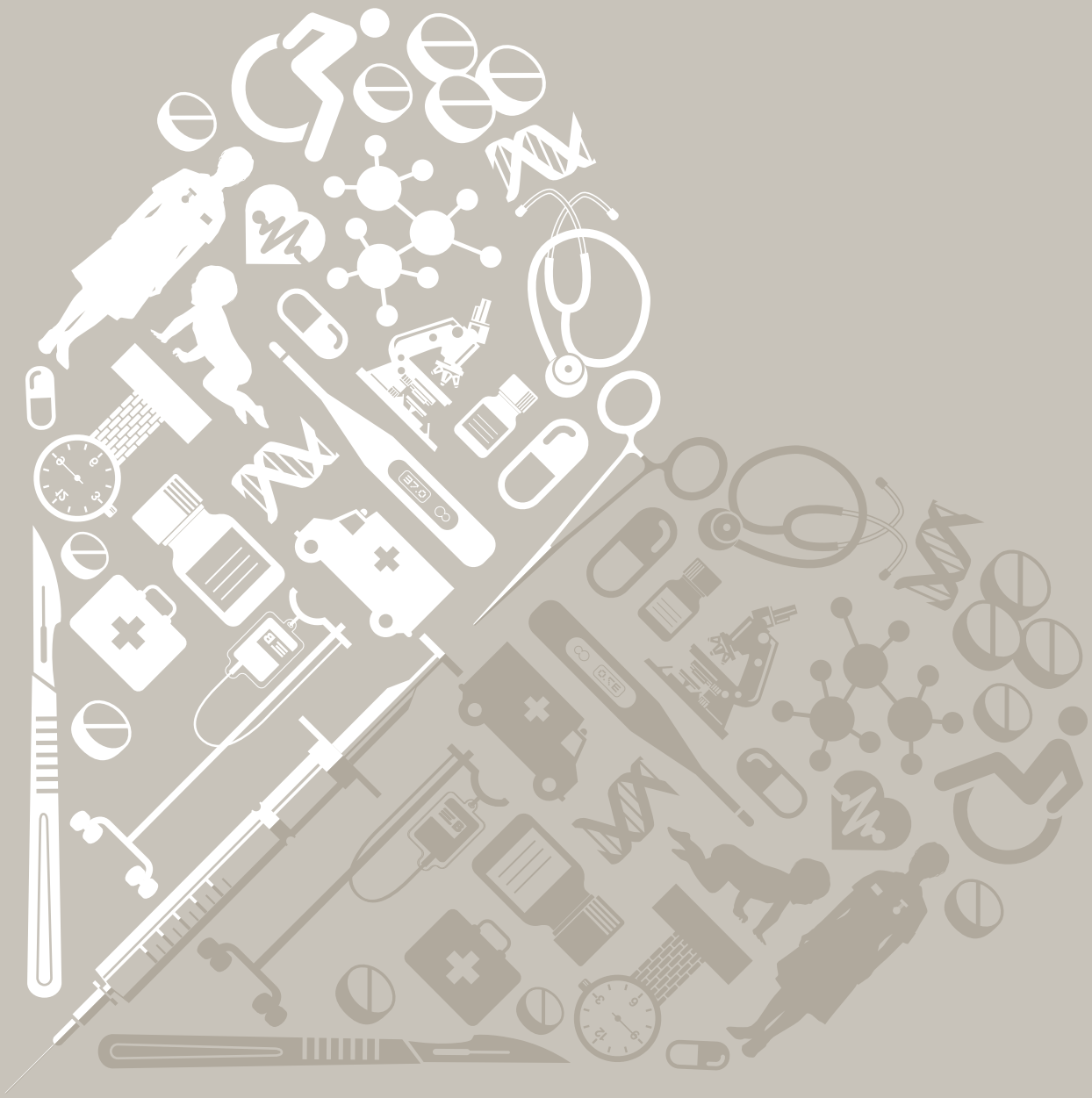


Awards and Congratulations

Engagement 2015 – Good, Better, Best Events

During July and December 2015, two events were held to engage with and thank staff for all their hard work. They were extremely well attended and provided staff with the opportunity to hear feedback about the Trust's current direction and also participate in work to inform the future plans of the L&D.

Luton Community Service Awards – Cliff Bygrave and Pam Brown

Two of the L&D's longest serving supporters, Cliff Bygrave and Pam Brown, were honoured at the Luton & Bedfordshire Community Awards 2015 held in Luton in October.

Chair of the L&D Charitable Fund Committee and former Non-Executive Director, Cliff Bygrave, won the Lifetime Achievement Award, and Pam Brown, former L&D Governor and leading fundraiser, won the Exceptional Achievement Award.

Chief Executive Pauline Philip, said: "Both Cliff and Pam continue to work tirelessly to support the Trust, and spread the good work of the L&D, as well as volunteering in the wider community. We would like to take this opportunity to publicly thank them for the extraordinary contribution they have made to our hospital."

HSJ 2015 Awards – Provider of the Year

The L&D was delighted to be shortlisted for a Health Service Journal (HSJ) Award 2015 in the 'Provider of the Year' Category. Representatives from the Trust attended the award ceremony on 18 November. While we did not win the award, the fact that we were shortlisted is an achievement in itself and a testament to all our staff who have worked so hard over the last year.

Longest Serving Volunteer – Eileen McMahon

A huge thank you and congratulations to our longest serving volunteer, Eileen McMahon, who has been awarded the British Empire Medal. A volunteer with us for 40 years, she offers her unique skills as a Skin Camouflage Practitioner not just for the benefit of patients at the L&D, but also for the charity 'Changing Faces'.

Eileen has received a number of awards over the years, including the Queens Medal via the British Red Cross, for her Services to Volunteering, but her most recent, the British Empire Medal, or BEM (for her services to the Community) was a real reason to celebrate and a party was held in her honour on 25 April.

Long Service Awards

On 25th February 2016, the Chief Executive was delighted to spend time, along with other Trust Board members, in the company of staff celebrating their long service with the Trust. In recognition of this we enjoyed Afternoon Tea where many memories were shared about the hospital over the past 25 years. It was a lovely afternoon which was made even better by the enthusiasm and passion shown by these staff still today.

Rosaleen Burke
Marion Cox
Jacqueline Davies
Anne Dolan
Lizan Drummond
Lesley Farbon
Valerie Galbraith
Joannah Griffey
Dawn Hardy
Louise McDonald
Kirstie Nicholls
Mary McCaffrey
Hayley Atkin
Jane Bottazi
Katie Dodd
Rosemary Gregory
Gio Healy
Gerry Hogan
Zeenath Mannan
Margaret Martin
Indiana Patterson- Blake
Karen Billington
Glenda Hall
Lata Sidpara
Nicola Wood
Elizabeth Elliot

British Medical Journal Nomination for Team of the Year - Gastroenterology Team

The L&D's Gastroenterology team has gone from strength to strength, drawing considerable national and international interest. Nominated twice as finalists in the British Medical Journal's Gastroenterology Team of the Year Awards for 2014 and 2015. This follows on from the success of being finalists at the 2014 Electronic Health Informatics Awards, and winning the British Society of Gastroenterology's SAGE (Shire Awards for Gastroenterology Excellence). The nominations and awards have come from the unique service we provide to our patients with inflammatory bowel disease.

Excellence in Volunteer Management Awards 2015 – Karen Bush

Congratulations to our Voluntary Services Manager, Karen Bush, who received a Special Commendation at the Volunteer Managements Awards 2015.

NAVSM is the National Association of Voluntary Services Managers, an organisation which supports and promotes best practice across the NHS. Karen received the Commendation at the Annual Training Seminar, and was recognised for the innovation of her role and the contribution it made to improving patient experience.

Top Teacher Awards

Following student nominations at University College of London, the following consultants have been singled out for praise by the students and awarded Top Teacher certificates:

Dr Ritwik Banerjee,
Consultant Physician & Endocrinologist

Dr Michael Eisenhut,
Consultant Paediatrician

Dr Trevor Hedges,
Consultant in Acute Paediatrics

Dr Parthipan Pillai,
Consultant in Respiratory Medicine

In addition, **Ms Su Gill** has received a certificate as a Top Administrator.

Governors who have completed their full terms of office

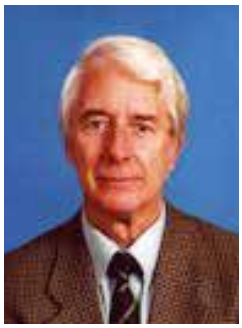
The L&D became a Foundation Trust with a Council of Governors in 2006. Each Governor is able to stay for a maximum of three terms of office and during 2015, six of our Governors, Pam Brown, Jack Wright, Cheryl Smart OBE, John Young, Malcolm Rainbow and Janet Curt reached the end of their third term which equated to nine years' service on the Council of Governors.

The Trust and the Council of Governors join in thanking them for all their hard work over the years. Their support by representing the views of the local people and staff, and helping the hospital to shape its plan for the future has been invaluable.

Jack Wright, Public Governor for Luton

Janet Curt, Public Governor for Bedfordshire

John Young, Public Governor for Luton



Malcolm Rainbow, Public Governor for Hertfordshire

Cheryl Smart OBE, Appointed Governor for the Chamber of Commerce

Pam Brown, Staff Governor for Volunteers

Nursing and Midwifery Awards 2015

Annually, the Trust holds an event for Nursing and Midwifery Awards. At the event held in May 2015, the following nurses, midwifes and care assistants won the awards.

Midwife of the year
Ilene Ngwenya
(with Chief Nurse, Pat Reid)

Student Nurse of the year
Partiva Gurung

Mentor of the year
Magin Limbaga

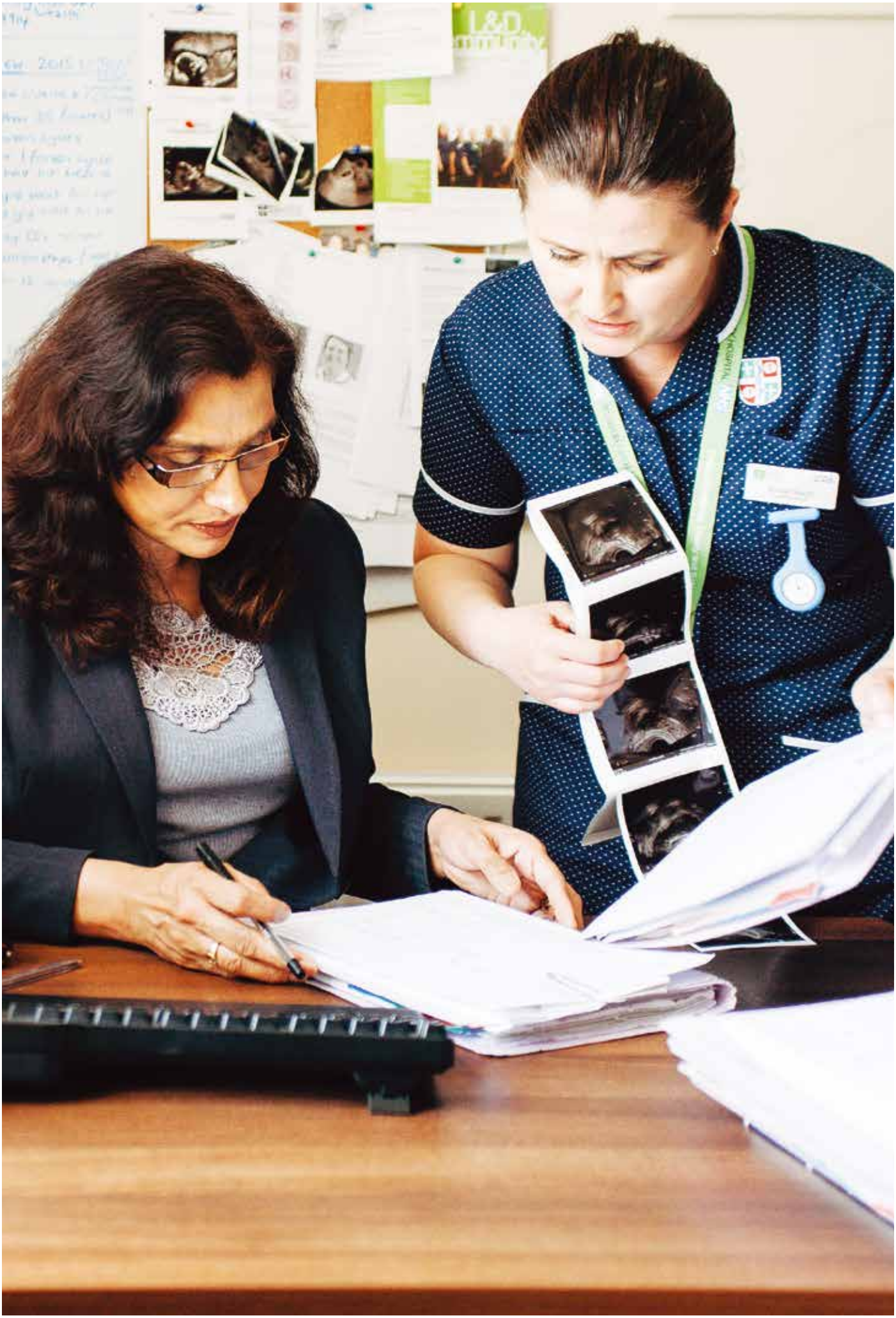
Student Midwife of the year
Joely Hodges

MCA/HCA of the year
Julie O'Connor

Most Promising New Graduate
The Aimee Varney Award
Joao Soares de Barros

Nurse of the year
The Erma Bristol Miller Award
Edmund Tabay
(with Chief Nurse, Pat Reid)

Nursing Team of the year
Ward 5, Rehabilitation


L&D

Introduction

In 2014 we published our 2 year Operational Plan which supported the implementation of our Strategic ambitions by detailing our Corporate Objectives and a number of key deliverables. This Annual Report sets out how we successfully delivered that plan in 2015/16 despite the significant challenges being experienced by NHS providers.

I am therefore both proud and humbled to report that L&D has been able to deliver against national quality and performance targets, achieving a Monitor governance rating of green for the last 13 quarters and a financial surplus for the 17th successive year. This performance is down to the extraordinary commitment of our staff and volunteers. The support of our external stakeholders was also of fundamental importance. Nowhere was the tremendous spirit of our staff more evident than during our 'Good, Better, Best' events that took place in July and December, when over 70% of our staff came together to identify the areas of our work that we do well and the key issues that they wanted to focus on to improve the quality and safety of the care that we provide.

During 2015/16, we expressed our keen interest in helping to restore the clinical and financial sustainability of the local health and social care system. We are now centrally involved in planning and executing transformational change across a planning footprint covering the resident populations of Bedfordshire CCG, Luton CCG, and Milton Keynes CCG (BLMK patch).

We are working with stakeholders and key players who are central to transformation across this footprint, including (but not limited to) the three CCGs and the two other secondary care NHS providers, the four councils and other statutory and non-statutory providers.

In line with the Five Year Forward View we will produce a Sustainability and Transformation Plan by the end of June 2016. We expect that the plan, following an examination of the current disposition of health and social care need, demand and supply in and around BLMK, will make recommendations that lead to:

- Service reconfiguration of hospital and out-of-hospital care currently delivered in BLMK by the three secondary care Trusts, a number of mental health and community primary providers and GPs.

- The introduction of a "new models of care" (NMOC) approach to population health management across BLMK, leading to a recalibration of how risks are handled in the local health system, and a redrawing of the traditional boundaries between commissioning and provision, potentially via the introduction of some form of Accountable Care Organisation vehicle.

Looking forward, The Board of Directors recognises the importance of sustaining the level of delivery against national quality and performance targets delivered by the Trust in recent years. We acknowledge that during 2016/17 the NHS will face even greater challenges but we are confident that by continuing to work with our staff and external partners, we will also have opportunities that will enable us to ensure that our patients receive the best possible clinical outcomes and have safe and high quality care.

Pauline Philip
Chief Executive

About this Report

The report follows best corporate practice reporting on the Trust's strategy and performance against the objectives. The report presents information on national targets and financial performance and also gives a review of the quality of services.

The report is structured as follows:

Introduction

Statements from the Chairman and the Chief Executive

Strategy

The Trust strategic vision, performance against 2015/16 objectives and the corporate objectives for 2016/17

Operational Performance Report

Includes performance against national targets, Research and Development and sustainability and climate change

Our Patients, Our Staff and Our Partners

Includes other information about patient care, staff, Equality and Diversity and working with partners

Governance Report

Includes details of the Board of Directors, Council of Governors and Foundation Trust membership

Financial Performance Report

Includes performance against financial targets and any risks for the future

Annual Governance Statement and Annual Accounts

Includes the Annual Governance Statement and the annual accounts

Quality Account

Includes details of the progress against quality objectives for 2015/16, the plans for 2016/17 and the annual quality statements.

Chairman's Statement

It is conventional for such a statement to end with appreciation of the contribution to an institution made by its staff and employees. In relation to the year just past, I would like to start by recognising and placing on record the debt of gratitude we owe all staff: the immense amount of effort (so very frequently beyond contractual hours); skill; good humour and their imagination in tackling new tasks with a clear desire, putting it very simply, to "put the patient first" – continually ahead of themselves. I don't believe they can be praised too highly.

The year has been marked with challenges, many of which have a very unfortunate habit of reinforcing each other. No institution can be stronger than its core customers and we have seen over the year that our lead commissioners Luton and Bedfordshire CCGs face severe financial strain, in large part because they have been paid below nationally agreed "capitation levels" (this has largely been changed for the year ahead). In addition Bedfordshire CCG has seen very significant changes in its senior management and board.

We have also seen attendance at hospital soar. It is to the great tribute of the hospital's management that we had anticipated this growth by increasing our capacity in terms of human resource and facilities; however, we realise that more needs to be done and we will introduce new initiatives and open another ward in late summer 2016 before starting work refurbishing others. To all those front line services which were disrupted by accepting patients on escalation days we pay particular gratitude. Also to those who have moved their services more than once to allow the hospital to reform itself for this increase in volume. At no time has patient safety been compromised but one cannot be so sanguine about patient comfort nor the impact on finances: patients for whom we are not paid at full rate occupy spaces that are normally used for other fee earning work, with staffing ratios in small areas that are designed for safety not for financial prudence. And, worse, many of these patients are "medically fit for discharge" and would much prefer to be back at home or in their local community.

We have recorded a modest surplus for the year but we must make clear that this has involved significant non-recurring items which cannot be repeated in the current year or years ahead. In agreeing our 2016/17 budget, we have identified four key areas where we will have to work with our core sponsors to deliver the surplus they require of us.

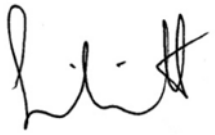
Over the year the hospital redevelopment was initiated with an initial phased £20m on "enabling works". Over the year £9.75m was spent on the opening of a new orthopaedic centre, a new Urology One Stop clinic, two new theatres, ward reconfigurations and the upgrading of the hospital facilities. The work on our redevelopment will now become part of a broader planning process covering the sustainability of health delivery in the Bedfordshire and East Buckinghamshire areas. This general Sustainability and Transformation Plan (STP) process is due to report to NHS Improvement (formally Monitor) and NHS England by 30 June 2016 and involves 16 key public sector bodies within the STP footprint; it is being led by our Chief Executive, Pauline Philip.

Finally, we have had our CQC inspection in January 2016 and we are currently awaiting the final report. The inspection was a positive experience and the staff welcomed the inspection team throughout the inspection process. The hospital has also been challenged throughout the year as we received no significant additional support beyond the relevant tariff paid for its services. We serve a community which faces its own challenges and which has had to face significant increase in activity over the last year, often by improvising solutions to ensure that all patients receive a timely and proper access to the hospital and we remain the only hospital in the country to achieve the 4 hour A&E target consistently. All I, as Chair, can do is to add my tributes to those that the inspectors have given and to record the immense planning and additional effort CQC visit entailed. I also commend the Inspection Team who did a difficult job on the ground with consideration and a clear desire to seek out the truth.

As we look forward to a year ahead can I also record and explain the changes in the board configuration. Dr Danielle Freedman has replaced Dr Mark Patten as the Chief Medical Advisor for the Trust, supported by three clinicians piloting the medical leadership position. Mark has taken up duties in UCL Partners in which we participate and we welcome Danielle back into a role she fulfilled previously. We thank Mark for his contribution and wish him well in his future role.

The Governors [have confirmed] further extensions to the term of office of Alison Clarke, now my Senior Independent Director (replacing Cliff Bygrave who is now chairing the Trust Charitable Funds Committee) and Vimal Tiwari and John Garner. But most particularly, in addition to leading the STP referred to earlier, Pauline Philip, our CEO, has been appointed, for part of her time, as the National Director for Urgent and Emergency Care. We applaud her effort on behalf of the nation's health but have also taken steps to ensure that she is able to continue to oversee the hospital along with David Carter, her Deputy, with the appointment of Sarah Wiles as her Chief of Staff.

These are very challenging times in health policy, in finances and in the demands the nation is placing on this hospital and the health economy more generally. I am, however, convinced that the team across the hospital is very able and very well placed to further improve that total health offering and to participate more broadly with others in the region in so doing. I commend the hospital and, particularly, the people within it for your appreciation and support.



Simon Linnett
Chair


NHS

Strategy

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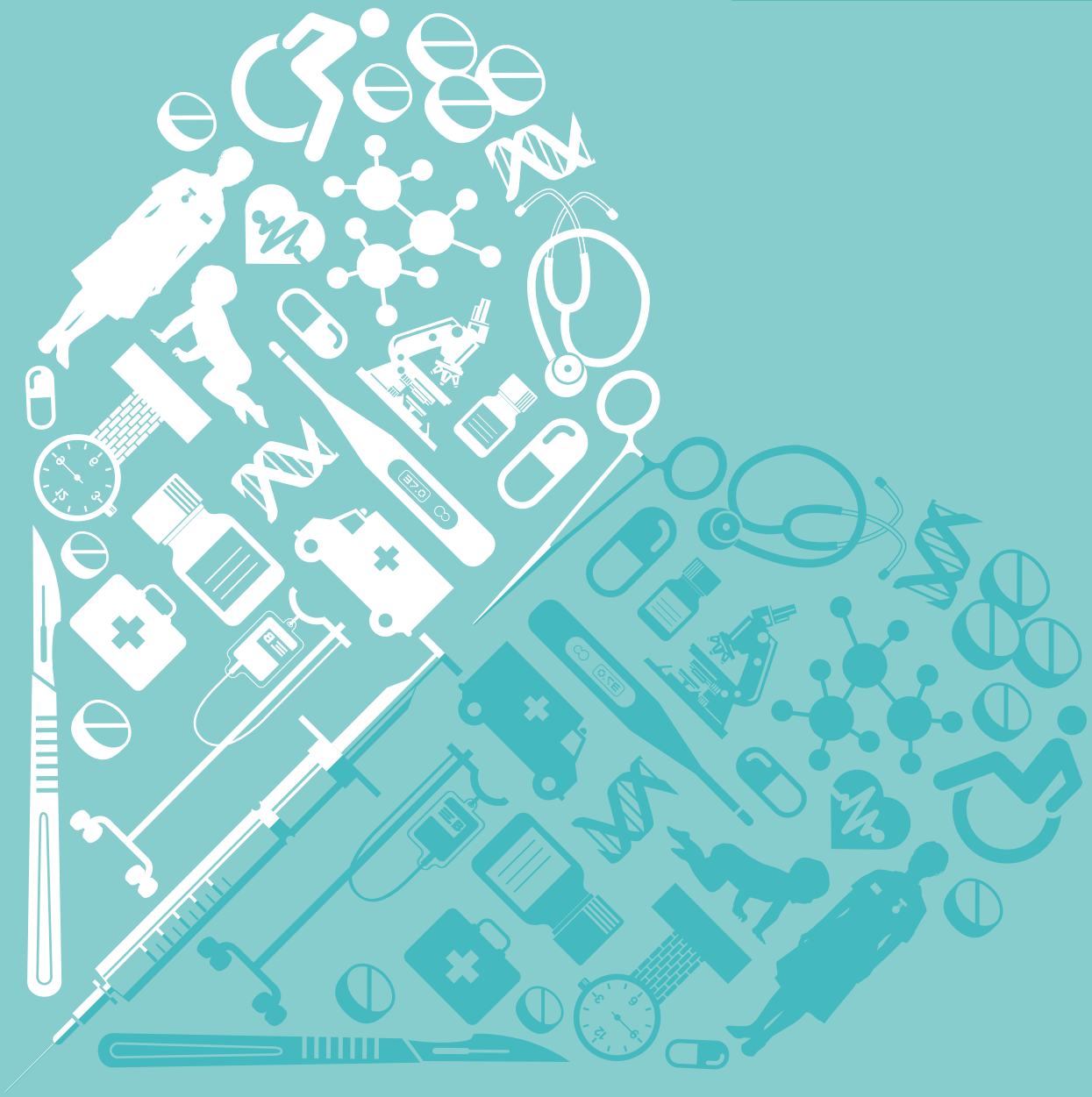

Strategic Vision

In June 2014, the Luton and Dunstable University Hospital NHS Foundation Trust (L&D) published a new five year strategic plan.

Vision statement

"The L&D is committed to delivering the best patient care, the best clinical knowledge and expertise using the best technology available and with kindness and understanding from all our staff"

That vision has informed the hospital's services and will continue to during the next four years'. Constantly striving to improve Clinical Outcome, Patient Safety and Patient Experience which is at the heart of everything we do.

The Trust has agreed a strategic vision for the next four years. The vision is the outcome of extensive work undertaken, including:

- the development of a clinical services strategy
- detailed analysis of the local health economy's requirements
- participation in the Healthier Together project
- a thorough review of emerging national policy, including the Keogh Report into Emergency Care, the Academy of Royal Colleges' report 'Seven Day Consultant Present Care' and the Better Care fund initiative
- joint working with local commissioners and other stakeholders
- an ongoing dialogue with our members and governors
- recognition that rising health care demand, rising costs and flat real funding means the Local Health Economy is facing a serious sustainability challenge.

Our vision is based on an understanding that patients will choose to receive acute hospital care from organisations that deliver:

- the best clinical outcomes
- a reputation for providing safe care
- high quality care
- care and diagnostics at the time of need

Our vision is consistent with:

- The overall focus and early direction of the Sustainability and Transformation Plan (STP)
- the emerging findings from the Bedford / Milton Keynes Review
- the knowledge available to us regarding the strategic intention of other providers
- the financial challenges facing our local CCGs
- the business development opportunities available to us to increase market share and to establish new services
- the strengths and weaknesses of the Trust

Our vision translates into a five year strategic plan, underpinned by six priorities:

1. Delivering Integrated Care, leading the work with external partners and stakeholders to ensure success in delivering care in the best place for patients.
2. Being a Major Emergency Centre; delivering 24x7 consultant-led A&E, emergency surgery, and acute medicine, supported by a level 3 critical care unit, enhanced trauma services and a specialist hyper-acute hub for vascular interventions, cardiac and stroke care.
3. Expanding our Women and Children's Centre, with our maternity unit providing extended consultant cover, in line with Royal Colleges' Guidelines and 7-day consultant led care supported by a level 3 NICU along with inpatient Paediatric Services.
4. Growing our Elective Centre; attracting both complex and non-complex elective activity from across the Local Health Economy and offering a high quality and efficient service for inpatient and day patient care.
5. Providing diagnostics at the time of need to support the delivery of integrated care for outpatients and the best possible clinical outcome for inpatients.
6. Advancing our commitment to training and teaching by: developing all staff groups; drawing on our clinical case mix and areas of established excellence, such as Human Factors; enhancing our commitment to undergraduate and postgraduate training; and increasing the scope of training to educational commissioners.

Values

- To put the patient first, working to ensure they receive the best possible clinical outcome and high quality safe care with dignity and respect.
- To value the contribution of staff, volunteers, members, governors and other partners and stakeholders, working collaboratively and professionally to deliver high quality clinical care.
- To focus on continuous improvement in the pursuit of excellence, maximising development opportunities.
- To manage our resources in a co-ordinated way, with an emphasis on productivity, value for money and quality.
- To see the diversity of our people as a strength, through our commitment to inclusion, equality and human rights.
- To accept responsibility for our actions, individually and collectively, to meet our obligations and deliver our commitments.

Performance against Corporate Objectives 2015/16

This section of the annual report reviews our performance against corporate objectives set out in our Operational Plan 2014-2016 (updated 2015). This also incorporates the work undertaken against the short term challenges facing the Trust. The progress that has been made against our quality priority objectives is reported in the Quality Account section of this document.

Objective 1: Deliver Excellent Clinical Outcomes

Year on year reduction in Hospital Standardised Mortality Ratio (HSMR) in all diagnostic categories

During 2015/16 the Trust identified that the 12-month rolling HSMR trend rose to being statistically higher than the national average.

The Trust Mortality Board produced an action plan and completed:

- Detailed case reviews of areas of concern
- Initiated ongoing reviews of all patient deaths
- Arranged for an external review of our response to the elevated HSMR.

To date no major clinical issue has been identified, although a series of service changes are planned, some of which have already been implemented to improve the overall quality of care patients receive.

Objective 2: Improve Patient Safety

a) Year on year reduction in clinical error resulting in harm

- We consistently achieved 98% harm free care.
- We continued to reduce the overall incidence of category two and three hospital acquired avoidable pressure ulcers. This was achieved through supporting and educating nursing staff across the organisation on the early identification, prompt validation and subsequent management of skin breakdown and continually learning through the Root Cause Analysis (RCA) process.
- We have maintained a falls rate of 4.32 per 1,000 bed days which is below the national average with continued challenges from an ageing and more frail population with complex health needs.
- We have achieved the 95% or greater target compliance of all VTE assessments.

b) Year on year reduction in Healthcare Acquired Infection (HCAI)

- We had one of the lowest C. Difficile infection rates in the country (11) and are assured that none of these were due to cross contamination.
- We have maintained a low rate of MRSA bacteraemias with only one case during 2015/16.

Objective 3: Improve Patient Experience

Year on year improvement in patient experience demonstrated through hospital and national patient surveys, leading to upper quartile performance

At the L&D, the Friends and Family Test (FFT) feedback is collected in a variety of ways: on paper forms; online through the hospital website and through telephone calls made to patients by staff in our Patient Experience Call Centre.

Between 90-5% of our inpatients would recommend the Trust and between 90-98% of outpatients.

The call centre provides us with further detailed information in real time from patients 48 hours following their discharge. This information is fed back directly to the wards and clinical areas to support the patients and change practices to improve the patient experience.

The annual national patient survey is demonstrating steady progress and some improvement. We are within the normal range when benchmarked against other hospitals nationally.

Objective 4: Deliver National Quality and Performance Targets

Delivering sustained performance with all CQC outcome measures

The Luton and Dunstable NHS Foundation Trust is fully registered with the CQC and its current registration status is **Registration without Conditions**.

No enforcement action has been taken against the Trust during the reporting period April 1st 2015 and 31st March 2016 and we have not participated in special reviews or investigations by the CQC during the reporting period.

The Care Quality Commission's(CQC) team of inspectors visited the hospital over three days in January 2016 to formally inspect and assess the quality of the care the Trust provides. We expect to know the outcome of the inspection in during 2016/17.

We implemented a programme of quality reviews with the leadership team to assess quality across the Trust services. Leaders within the organisation were assigned a 'buddy' area and were required to complete weekly visits and escalate any issues. This process provided 'board to ward' reviews and also supported staff to raise concerns and issues to the management team. It also supported a key part of the Trust preparation for the CQC inspection. This programme has developed into a revised quality monitoring framework.

Delivering nationally mandated waiting times and other indicators

- During 2015/16, the L&D continued to consistently deliver against national quality and performance targets, achieving a Monitor governance rating of green throughout the year.

In addition, the L&D:

- Was the only Trust in the country to achieve the emergency care 4 hour national target every week despite experiencing both a high volume of Emergency Department attendances and an increase in admissions.

- Met or improved upon the national standards for patients not waiting more than 18 weeks for treatment from the point of referral in all quarters.

- Met all of the cancer targets for the year with the exception of the 2 week wait for breast symptomatic breast patients in Quarter 2. This was due to the temporary closure of another local unit which resulted in unexpected volumes of patients. The position was recovered in the following quarter and overall the Trust has delivered one of the best cancer performances in the country.

- Had excellent performance for C Difficile maintaining a low rate of 11 (one of the lowest in the country and below the de minimis of 12) but this did exceed the agreed contract threshold of 6.

- Reported 1 MRSA Bacteraemia which is also under the de minimis of six for reporting to Monitor.

Objective 5: Implement our New Strategic Plan

During 2015/16 a number of key strategic developments supported the delivery of the Trust's Strategic Vision.

a) Delivering new service models:

Emergency Hospital

- **Repatriated CT Coronary Angiography (CTCA)** - Through collaborative working with Imaging and supported by Harefield Hospital, CTCA is now delivered locally, with a plan for full repatriation planned in 2016. This has resulted in an improved patient pathway, better value to the local health economy and provided opportunities for staff learning and development.

- **Continued development of Ambulatory Care** - The Trust continued to optimise the Ambulatory Care Service in order to increase the number of patients managed on alternative care pathways to hospital admission through extended operational hours.

- **Further developed stroke services** – in 2015/16, stroke services were enhanced through the successful recruitment of additional stroke physicians and stroke specialist nurses.

- **Initiated the transition to Needs Based Care model** – The Trust made progress towards a needs based service (where patients are cared for by their diagnosis rather than their age) and planning began for a larger cardiology ward to facilitate this.

Women & Children's Hospital

- **Developed gynaecology community pathways** - The gynaecology team have worked effectively with West Herts' commissioning teams and other local providers to establish community services supporting specialist assessment and provision. Services are now provided in Harpenden and Hemel Hempstead.

- **Employment of a Consultant Midwife** – A Consultant midwife is working across a number of areas including community midwifery to provide enhanced services for women and promoting normality in child birth. The Trust has continued to recruit both qualified midwives and additional maternity care workers to support mothers antenatally and postnatally.

- **Continued close working with local community services and GPs** - Children's services have continued to work with primary and secondary care to ensure

families who have children with long term health needs receive a joined up service. Working with Luton GPs and community nurses has provided a passport for children giving them clarity on what and how to access services according to individual need and ensuring rapid access to primary care to prevent avoidable hospital attendance.

Elective Centre

- **Continued to work on developing Specialist Vascular Services -** As part of the Trust's 5 year strategic plan, re-establishing vascular services at the L&D was identified as a key opportunity to enhance and complete our hyper-acute portfolio. Work has continued during 2015/16, on the development of the operational model for Vascular services and a scoping paper was sent to Specialised Commissioning for their review. The proposed model is a centralisation of vascular arterial work at the L&D.

- **Opened the new Urology one-stop diagnostic clinic –** The new Urology one-stop clinic facility opened on the 1st September 2015. The model of care enables patients to have a comprehensive diagnostic work-up at the time of their first appointment and is the only service of its kind in the local area. Patient feedback has been excellent, and the new facility has enabled the clinic to run efficiently and provide a good environment for staff and patients.

- **Increased elective surgery theatre provision –** The Trust invested in two new theatres. One replaced a vanguard rental theatre whilst the other provides additional capacity. This has provided much needed additional operating capacity for services, enabling us to reduce our orthopaedic waiting list, and removed the financial burden of the Vanguard rental charge, resulting in a significant cost saving for the Trust.

- **Opened the new Orthopaedic Centre –** Our flagship orthopaedic centre was opened in November 2015, with facilities for elective orthopaedic and community musculoskeletal services as well as fracture clinic, including brand new digital imaging equipment. This has freed up much needed clinic space on the main site to enable the expansion of clinical services.

Information Management and Technology

- Advanced IT Infrastructure and Service Desk – We are entering year 4 of our infrastructure managed service. We are currently managing over 400 servers on our primary site at Luton and in our secondary Data Centre in Huntingdon. The aim of the Infrastructure investment was to give us a 21st century platform on which to expand and grow with the best up-time performance for our 24/7 healthcare services. We have also invested in new software to manage internal service calls that have risen 30% in the last year as the use of information technology as become embedded in our services.

b) Implementation of our preferred option for the re-development of the hospital site.

- A design team consortium, led by AECOM, completed the design work required to support the preparation of the Outline Business Case (OBC) for the redevelopment in July 2015. This culminated in the submission of a detailed planning application to Luton Borough Council at the end of July 2015.

- Planning Consent for the scheme was granted by Luton Borough Council in February 2016.

- The Outline Business Case for the redevelopment of the site was reviewed and approved by the Board of Directors at the meeting held on 28th October 2015.

- The Trust elected to proceed with the next stage of design in phases. Work commenced on development of the detailed design for the new Services Block in October 15, and was completed at the end of March 16. This information will support procurement of a building contractor for this element of the project.

- Design work for the balance of the scheme has been paused until the outcome of the Sustainability and Transformation Plan (STP) is known. Work to prepare the Full Business Case (FBC) for the scheme is continuing, but procurement will not commence until such time as the activity plan for the site has been agreed by the Department of Health.

- The Trust received a loan of £19.9m from the Independent Trust Financing Facility (ITFF) to support the delivery of enabling works required by the redevelopment plan.

- During 2015/16, the new orthopaedic centre was opened in November 2015allowing the centralisation of orthopaedic activity in a purpose built facility.

- Part of the ground floor of St Mary's was refurbished to deliver a new 28 bed ward. Work will continue in 2016 to deliver a second ward in St Mary's, and to carry out an extensive refurbishment of wards 10, 11 & 12.

- Two new modular theatres were opened in January 2016. These are modern laminar flow theatres to support orthopaedic activity. The temporary Vanguard unit has now been removed.

Objective 6: Secure and Develop a Workforce to meet the needs of our patients

a) Develop and monitor the delivery of a comprehensive recruitment programme for all staff groups. The programme will incorporate a work plan focusing on retention.

The Trust continues to recruit staff both locally, nationally and internationally. The Trust hosts bi monthly recruitment events for both nurses and HCAs along with bi monthly European recruitment.

This recruitment is monitored on a monthly basis by the Trust Board along with other hard to fill vacancies.

Retention has been and continues to be a key component of our strategy and the Trust recently reviewed and re-launched its starter and leaver questionnaires so that we can understand better why people join the Trust as well as why they leave. In addition to this the Trust introduced a nurse bank shift staff incentive scheme where certain staff groups can win prizes for working bank shifts.

b) Ensure a culture where all staff understand the vision of the organisation and are highly motivated to deliver the best possible clinical outcomes.

- At the heart of L&D is a culture of staff ownership and involvement. This culture is nurtured by a comprehensive range of communication and engagement activities. Particularly important are the large scale, Trust wide 'Good, Better, Best events' where all staff come together to agree quality priorities and monitor progress in improving clinical outcome, patient safety and patient experience. During 2015/16, these events were held in July and December 2015.

The events were held over a week and over 70% of our staff attended each event in July and December. Both events engaged with our staff to provide them with key information about the Trust and gather their feedback about what the Trust does well and any areas for improvement with clear actions identified. These resulted in communication back out to staff with this information. The events were also an opportunity to thank the staff and also hear from our patients.

- We also receive assurance from our NHS National Staff Survey and our overall staff engagement score was 3.84 (on a scale of 1 - 5), this was above average when compared to all Acute trusts.

c) As a University Hospital, deliver excellence in teaching and research. Ensure that all staff have access to appropriate education and facilities to maintain their competence

Medical Education

- Delivery of high quality training and education continued to remain a priority for the Trust in 2015/16. Over this year we have embedded the governance structure for both undergraduate and postgraduate training. All the Educational supervisors have been formally appointed and will as part of their annual appraisal have their educational roles formally appraised. This will enhance the quality of the educational role strengthening the standard of the educational supervision. The Trust has been implementing the recommendations outlined by the GMC in preparation for the accreditation and appraisal of Educational Supervisors and Educational Faculty by July 2016.

Undergraduate

- Our undergraduate medical training continued to develop and increase the clinical specialties supporting studies. We continue to receive high satisfaction rating from UCLH students. At the end of 2015 we were successful in appointing two Undergraduate tutors. The team continue to work with the University improving the student rotations with enhanced clinical exposure and bedside teaching. Over the next year we hope to look at supporting the University and consider supporting exams and placements for year 3 and 4 students.

Postgraduate

- We are committed to ensuring that the quality of training for postgraduate medical trainees delivers the requirements of the curriculum. During 2015/2016, we received a combined Quality performance visit for Medical and Non-medical trainees. We received positive feedback with a very small number of recommendations which are being addressed.

- During 2015/16, Health Education East of England (HEEoE) Local Education and Training Board visited the following departments - Medicine, Anaesthetics, and Ophthalmology. All three visits resulted in some required actions for us and these are again being addressed. Key feedback from the visits include:

Medicine

- The joint visiting team (HEEoE and GMC) were pleased with the clear progress the department has made. They were positive that the department has been able to make an improvement in the training environment and recognised a change in the culture.

- They made some recommendations with regards to IT governance, patient tracking and departmental induction for trainees. The Trust Steering group set up in 2014 continues to meet regularly work on the action plan giving feedback to HEEoE and the GMC on a regular basis.

Ophthalmology

- The department received positive verbal feedback from the visiting team. A formal report is awaited but the main recommendation concerned the availability of space within the clinic setting. Once the formal report is received a formal action plan will be submitted.

Anaesthetics

- The department received positive verbal and written feedback from trainees. The trainees reported that their training needs were being met and they reported that they felt well supported.

- Following the formal report the recommendations made have been met and this has been reported back to the deanery with a clear plan of the plan of action.

Objective 7: Optimise the Financial position

Delivering our financial plan 2014-2016 with particular focus on the implementation of Re-Engineering Programmes (REP)

The REP has continued to pull together various initiatives into a coherent portfolio of projects. The REP is fundamental to the ongoing viability of the organisation as it strives to meet the challenges of tariff efficiency. The overall approach is based on the analysis that suggests the Trust's systems and processes are not functioning to a maximum level of efficiency and that potential improvements represent a key opportunity. The REP aims to meet the financial challenge by creating overall 'system' efficiency rather than delivering discrete cost reductions unconnected to the whole. The Corporate schemes outlined below have been the focus for this year:

- Outpatient (OP) Re-engineering – where considerable progress has been made towards effective waiting list management with patients only being booked when a confirmed appointment is available. This Partial Booking approach will be completed early in the summer of 2016. This has reduced wasted capacity by reducing Did Not Attend levels, allowing appointments to be utilised. In addition there has been a focus on completing the roll-out of electronic room booking which is enabling room utilisation rates to be known. This has also enabled a recharge for use of OP resources which it is hoped will see an improvement in utilisation. The OP day has also been extended in a planned fashion to allow the well-received running of planned clinics on Thursday evenings and Saturday mornings.

- The implementation of an electronic staff rostering system (eRostering) has continued apace with the completion of the most complex areas including theatres and the delivery suite. All nursing and support areas are now live. The project focus has moved onto benefit realisation by improving auto-rostering and reducing the amount of contracted unused hours.

- We have developed service provision during 2015/16:

  - Launching the provision of antenatal services from Leighton Buzzard, supported by remote ultrasound allowing much more convenient pathways for patients in that local area.
  - Proactive GP engagement as shown by increased attendance at engagement events.
  - Supported a successful bid to deliver an innovative new model of Sexual Health Services in Luton.

- The Re-engineering programme is embedded into the Division's annual plans and are reported back in this report through the corporate objective review, divisional performance review and quality accounts.

Service Developments delivered in 2015/16

During 2015/16, the Division of Surgery:

- **Recruited a 7th Oral and Maxillo-facial Consultant** – The division successfully recruited a 7th Oral and Maxillo-facial Consultant to assist with the increasing workload for the service.

- **Remodelled ENT clinic** - A new triage and appointment management model has been established to ensure good streaming through the clinics. This was in response to long clinic waits and poor flow through clinics.

- **Introduced a new model of Surgical Emergency Cover** - The Surgical Assessment Unit was established in June 2015. In addition, the new emergency model in general surgery, colorectal surgery and urology has significantly increased the time available for consultants to deliver emergency care. This combined investment has reduced the length of time to senior review for emergency surgical admissions, and ensures that a specialist surgeon for each sub-specialty is available for emergency theatre every day.

- **Expanded Specialist Palliative Care Team** – With the support of Macmillan Cancer Support, the team has successfully recruited to new nurse posts including a new End of Life Nurse.

- **Reconfigured the one-stop breast clinics** - The one-stop breast service offers a first class diagnostic and consultation service to women who are worried about the possibility of a diagnosis of breast cancer, and receives extremely positive patient and staff feedback. To ensure a more even spread through the week and ensure that symptomatic patients referred to breast services by GPs can be offered a first choice of appointment within 7 days of referral.

- **Designed an improved patient flow in orthopaedic clinics** - Working with specialists in improvement methodologies, the orthopaedics and imaging team carried out detailed observational analysis and worked to remodel the flow through their outpatient clinics to ensure best use of imaging and plaster room staff and improve outpatient experience for patients. The new templates were to fully implemented in May 2016.

- **Established the business case for 24-7 outreach** – The Division has implemented robust cover for patients requiring set-up on non-invasive ventilation. Funding was secured for expansion of the specialist critical care outreach service and the extended rota was scheduled to commence in April 2016.

- **Extended the Enhanced Recovery Programme** – The length of stay for elective colorectal inpatients on enhanced recovery pathways continued to reduce and during 2015/16 the team extended this support to emergency patients. This programme receives excellent patient feedback and improves outcomes for patients by ensuring that all elements of the per-operative pathway are optimised.

During 2015/16, the Division of Medicine:

- **Developed new governance structures** - To support the delivery of Trust priorities and acknowledging the challenges of managing the Division of Medicine as a single entity, the Divisional structure was reorganised in 2015 providing greater autonomy and decision making at specialty level. The underlying principles for the change included facilitating clinician engagement, allowing devolution of decision making and ensuring appropriate accountability within an agreed framework. The scope of Directorates now includes Specialist, Acute, General, Elderly, Emergency and Stroke Medicine. Clinical Directors and Speciality Leads were appointed from the beginning of September 2015 and Directorate and governance meetings were embedded across all areas in 2015 with standardised agendas and Terms of Reference.

- **Implemented service line management** - During 2015/16 the Division commenced the integration of operational and financial performance to enable clinicians to lead and develop services and support delivery of the best clinical and financial outcomes.

- **Utilised demand and capacity analysis to inform specialty strategies and service development** - Capacity and demand analysis has been utilised to guide business planning and decision making - for example in Sexual Health and Rheumatology services.

- **Improved the transcription service** - The Division worked with clinical teams to support the timely delivery of clinical correspondence to patients and their GPs. A sustainable improvement in typing clinic correspondence was achieved during 2015/16 through demand and capacity planning, effective recruitment and training, initiative typing and joint working with departmental secretaries. Going forward in 2016/17 quality improvements will continue through collaborative working with clinical teams to optimise correspondence accuracy, standardise templates and provide ongoing training and team building.

- **Rolled out partial booking across medicine specialities** - Following the successful introduction of partial booking in rheumatology, the division has worked in collaboration with the re-engineering team to roll out partial booking to other specialities, including respiratory. This has improved clinical efficiency and significantly improved patient experience of clinics and significantly improves patient experience. This work will continue through 2016.

- **Transformed the Rheumatology service** - In 2015 a business case for the transformation of rheumatology services was approved including the recruitment of three additional Rheumatology Consultants. This provides increased capacity for early access to specialist care, including Early Inflammatory Arthritis, and has resulted in achieving the Best Practice Tariff. The introduction of ultrasound in rheumatology outpatient clinics has supported early diagnosis and treatment. Further expansion has included developing a metabolic bone service, including DXA reporting for bone density.

- **Commenced a 24/7 service for unstable patients with Acute Upper Gastrointestinal Bleed (AUGIB)** - A 24/7 AUGIB rota was implemented in January 2016. Plans to further train and develop nurses within endoscopy and through collaborative working with theatres is planned. The service will be subject to on-going monitoring during 2016/17.

- **Achieved British Society Echocardiography (BSE) Departmental Accreditation** - The division continues to work towards gaining BSE Departmental Accreditation, demonstrating quality and excellence through benchmarking services. Three Cardiac Physiologists have gained individual BSE accreditation with a further three expected to be accredited in 2016/17.

- **Worked collaboratively across diabetes and maternity services to develop diabetes in pregnancy services** – this work continues to further develop the service available for pregnant women.

- **Further developed insulin pump service** - the development of the insulin pump service, including the introduction of telephone clinics, has enhanced care through improved access and patient experience.

- **Provided Diabetes training to staff** – the division completed an expansion of inpatient teaching with additional sessions made available for qualified nurses and HCAs. Weekly Junior Doctor open teaching sessions on insulin were also introduced as well as statutory midwife training sessions, and the development of a new specialist midwife post.

- **Expanded the Nutrition Nursing Service** – the division supported the provision of enteral and parenteral nutrition for patients, provided specialist training and support for hospital teams across the Trust.

- **Developed the Prosthetic and Orthotic service** – the division completed the successful implementation of electronic note keeping in both Prosthetic and Orthotic Services. The Gait Analysis plate is also now fully operational used mainly in Prosthetics for assessment and validation of prescription.

During 2015/16, the Division of Women and Children's Division:

- **Continued to improve the facilities in maternity** - The 'Forget-me-not' Someries Suite was formally re-opened in March 2016 following refurbishment. This alongside further staff training will enable the Trust to support bereaved families more appropriately. In addition further ensuites have been provided on the delivery suite.

- **Completed further pathway redesign** - Improved antenatal assessments have been put in place to ensure a better understanding and response to individual family needs. This includes greater emphasis on paternal support and understanding of additional needs for families with mild and moderate learning disabilities.

- **Provided more parents' accommodation and improved facilities on the Neonatal unit** - Thanks to the support of the Hospital charitable funds and individual family fundraising we were proud to open the new parents' accommodation in a property on Calnwood Road. This provides accommodation for up to three couples who have babies being cared for in the neonatal unit. Feedback from families has been very positive.

- **Worked in partnership with Keech Hospice** – Consultant paediatrician support to Leech Children's Hospice is now in place along with continued support through training and close working across clinical and managerial boundaries.

During 2015/16, the Diagnostics, Therapeutics and Outpatients Division:

- **Commenced CT Coronary Angiography (CTCA) service** - The Imaging Department, in collaboration with Cardiology, successfully established and repatriated a CT coronary angiography service in 2015, providing benefits to patients with a faster and more localised service, including diagnostics,

supported by the appointment of a specialist cardiac radiologist and specialist training to radiographers.

- **Invested in Imaging** - To meet Trust wide service developments, Imaging has benefited from the appointment of an additional three consultant radiologists during the course of 2015/16 to support nuclear medicine, cardiac and MSK work, and to expand the in-house reporting capacity of consultants to help deliver inpatient Keogh performance standards. The implementation of the strategic imaging picture archive system (PACS) has also been achieved and the plans and investment for the 4th ultrasound room have been approved. Further expansion of MRI provision has been implemented to facilitate improved access and the training of radiographers and mammographers into extended roles has been initiated to future proof service development and support sustainability.

- **Commenced Laboratory Information Management System (LIMS) procurement** – Pathology has successfully tendered for a replacement LIMS over the course of the last year and initiated improved shift patterns in Blood Sciences to deliver better 24/7 substantive staff presence. The implementation of the LIMS during 2016 will support improved efficiencies and continued service modernisation across each of the Pathology disciplines. Microbiology has proactively supported Medicine in the successful bid to provide GUM services in Luton.

- **Continued Outpatient re-engineering** – The pilot of partial booking has demonstrated benefits in the specialties when it has gone live, including Rheumatology, ENT, Respiratory, Trauma and Orthopaedics and Urology, achieving reduced rescheduling and improving DNA rates. The Trust has supported the implementation of partial booking across all specialties to achieve maximum benefit and the creation of the patient pathway co-ordinator role has provided development opportunities for Outpatient administrative staff. The Trust took a decision to defer implementation of self check-in in 2015 pending the potential replacement of the hospital's Patient Administration System (PAS) in 16/17.

- **Service relocation and reconfiguration completed** – DTO has proactively supported several strategic service reconfigurations during the course of the last year, including the relocation of the Fracture Clinic and establishment of the Orthopaedic Centre, reconfiguration and development of new MSK facilities and rationalisation of Outpatient and Therapy services to accommodate new ward developments in St Mary's Wing. This challenge continues into 2016/17, facilitated by development of evening and Saturday outpatient clinics to maintain Outpatient services, create opportunity for growth and improve patient choice.

- **Improved Therapies, Dietetics and Pharmacy services** – The majority of Dietetic staff formerly employed by SEPT have successfully been TUPE transferred to the Trust in the last year to provide improved service resilience and development. The Trust is now considering options to extend insourcing of therapy support. Meanwhile Pharmacy has proactively supported the Trust wide roll out of Electronic Prescribing and Medicines Administration system and continues the programme towards e-oncology implementation.

- **Evaluation of the NPfIT Electronic Patient Record (ePR)** – The Trust evaluated the NPfIT offering, Lorenzo, which is a modern Patient administration system which has a number of modular components, such as maternity, emergency medicine and bed management allowing an integrated patient record. We mapped our integration architecture now and for the future, and produced a Full Business Case which was presented to the Finance, Investment and Performance Committee in March 2016. We visited a number of NHS Trusts and learned so much from them to enable us to put together a deployment plan to achieve minimum impact on our operational performance whilst achieving the most benefits out of the system. We are currently exploring the correct strategic direction given the requirements of the newly launched STP process within our region.

- **Evolve Clinician User Forum which will become the Clinical IT Users forum** – This forum which has developed out of the Evolve electronic notes project is chaired by Mr. Taneja, a Consultant Urologist and our Chief Clinical Information Officer. Its purpose is to gather Clinicians views and thoughts on the current Trust IT systems and devices and share experiences to inform a better overall platform for clinicians to work on. We are currently exploring storage solutions for Medical Images and traces, e Form creation and strategies for accessing data and information from our multiple systems to aid audit and benchmarking.

- **Solutions Board** – The Solutions Board, which is a sub-group of the Information Systems Steering Board, meets to evaluate the proposed IT project portfolio, taking into consideration business need, cost, priority, complexity, integration needs and engagement requirements. During our focus on a National PAS & ePR solution we held the meetings less frequently, but

we are now back to the normal timetable to ensure we manage the IT project resource appropriately and get the correct level of clinical involvement in the decisions that are taken.

During 2015/16, corporately we:

- **Implemented E-Prescribing and medicines administration** – We have currently rolled out the ePMA JAC system throughout Medicine, DME, Paediatrics, Theatres, Surgery including main Theatres, admitted patients in ED and the current contingency areas. We are proposing a second phase of the project to complete the roll out to all areas in 2016/7, including a full upgrade of the system in late summer 2016. The project is overseen by the Department of Health, as it was partly funded via a grant for the Technology Fund. The project is closely linked to the Virtual Desktop rollout programme and the Wi Fi upgrade, as these are key enablers to ensure success.

- **Implemented Unified Communications** – This has been a very large programme of work, involving the upgrade of the current Trust Network, new core switches deployed across the Trust to give more capacity to handle the IT communications as well as the Voice element. The Network team minimised downtime across the Trust by installing shadow networks in key areas, such as A&E, to ensure minimal service impact. We have also installed two new cabled connections to alternative locations to give the telephony system full resilience when completed. We have configured the servers and trialled the applications within the IT department and other key locations, and are now in a position to rollout the new handsets across the Trust in a six month deployment plan.

- **Implemented electronic blood tracking** - The Trust has also continued to implement electronic blood tracking, and this project is very near completion throughout the Trust. Further uses of the software have been found, for instance using it to track and administer breast milk in Maternity.

- **Began the rollout of the Virtual Desktop Infrastructure (VDI)** – Last year the IT Department began to rollout the VDI; this followed a significant effort to setup and test the new environment during 2015. Numerous areas including the Orthopaedic Centre, Fertility Clinic and parts of A&E are now benefiting from the new VDI environment. Once VDI is rolled out users will benefit from a quicker, more stable Microsoft Windows 7 environment that offers true virtual computing running from the Trust's private cloud computing infrastructure.

- **Reviewed and Implemented a new PACS store** - The old NPfiT Agfa PACS was transitioned in 2015 from the National PACS store to the Trust Infrastructure successfully. In parallel to that the PACS Project Board carried out a procurement exercise to purchase a new PACS system and an independent archive (VNA). The successful companies, Carestream for PACS and Visbion for the VNA have worked with the Trust project team, comprised of Radiology & IT members, to migrate the historic images to the VNA and swap out the Agfa PACS system to transition to the Carestream platform. This has been achieved, and we are now in the final phase of evaluating and transitioning the system into business as usual.

2016/17 Strategic Approach

Introduction

NHS England (NHSE) and NHS Improvement (NHSI) issued joint planning guidance towards the end of 2015 requiring NHS bodies to come together within agreed "footprints" and to produce a five year[1] place-based *Sustainability & Transformation Plan (STP)*.

A total of 44 footprints have now been established in England. The area covering health and social care bodies in Bedfordshire, Luton and Milton Keynes (or BLMK) is one such footprint. Our Chief Executive Pauline Philip has been asked to lead the work to formulate the STP across this footprint.

Key dates for formulating and agreeing the STP are:

- For the STP footprint to be determined locally by 29th January 2016
- A formal written submission from each STP footprint summarising STP governance arrangements, key gaps to be scrutinised and addressed in the STP and priorities that are likely to emerge for remedial action when implementing the STP by 15th April 2016
- For the 1st draft of STPs to be formulated, agreed and submitted to NHSE/NHSI by 30th June 2016 with a view to their finalisation by 31st July 2016.

To help define, prioritise and guide the development of the STP in the coming months, 16 local health and social care organisations have agreed to work together. A Steering Group has been established, comprising senior executive management from all 16 "STP Partners". This includes all three CCGs, the four local Councils and the larger NHS service providers.
By summer 2016, the STP Steering Group needs to produce and submit to NHSE/NHSI an STP that covers the whole of BLMK, and for that STP to be approved, adopted and activated. The STP needs:

i. To set out a clear set of measurable activities, with an associated timeline, to be implemented, as well as the required resources and investment associated with such activities.

ii. To define and establish the system leadership apparatus, and the required resources, to implement those activities, expeditiously over the five-year planning period.

iii. To ensure that the 2016/17 Operating Plans of all key NHS bodies in Luton, Bedfordshire and Milton Keynes are harmonised with the STP.

What is the STP seeking to achieve?

The goals of the STP, as defined by the STP Steering Group, are:

i. create the conditions within which plans formulated as part of the STP can be successfully implemented, by uniting key participants across the BLMK health and social care system around the programme of work set out in the STP.

ii. ensure the local population is better informed about how they can stay healthier, how they can detect and act on early warning signs, how they can access the health and social care system at the right point and at the right time, and with the appetite, capability and support to take control of their own care needs.

iii. enable and engineer a step improvement in the personal physical and mental health of the local population, so that years are added to life, and the variance in life expectancy across BLMK narrows markedly.

iv. fully utilise the contribution that primary, community and social care can make by creating a technology-enabled, operationally integrated and professionally sustainable model of Primary, Community & Social Care operates across the STP footprint, 7-days a week, intervening earlier and in a less intensive way, harnessing the contribution of personal, community and voluntary networks, and maximising health and social care provided in or close to the home.

v. establish a safe and clinically sustainable solution for Secondary Care Services operating across the STP footprint, 7-days a week, and meeting all relevant national quality and performance standards.

vi. by leading-edge population health analytics, to establish new models of care, and associated capabilities, infrastructure, organisational structures and fiscal relationships that:

- That are fit for purpose for delivering 1st class, integrated health and social care into the mid-21st century
- Which place the public and patients (in terms of both their safety and their involvement) front and centre
- That address head-on health inequalities
- That allocate risks and incentives in new ways and which align and underpin the vision of prevention and health promotion, of more self-care and of earlier and less intensive intervention in out-of-hospital settings

[1] Covering the 5-year period between 2016/17 and 2020/21

vii. To enable all statutory bodies involved in the health and social care system in Luton, Bedfordshire and Milton Keynes to live within the financial means available to them.

Implications for the L&D Strategy

As a result of preparatory work undertaken by the STP Steering Group, a total of nine workstreams have now been initiated. L&D is already closely involved in the design and development of these workstreams, and will remain centrally involved in the implementation of such workstreams.

Many of the STP workstreams aim to strengthen services operating outside hospital. This will be welcome development for L&D, and might alleviate some of the pressures that result from dealing with inappropriate patients presenting at the hospital. Equally, it is likely that the L&D will be the acknowledged specialist lead hospital across BLMK, with some specialist services being more clearly focused at the L&D.

In addition, though, with integration being such a prominent feature of the models being examined, L&D might expect to be challenged to make a more telling contribution in care settings away from the hospital. This might manifest itself through the delivery of acute services and/or the acute underpinning support into non-acute services in community settings, or by L&D adopting a leadership and development role to create more robust clinical networks that function across care settings. Finally, L&D might be asked to formulate its thinking in respect of future clinical support, ancillary or administrative services by reference to the whole STP footprint.

The next key milestone is the production of plans arising from these workstreams that can then be collated and aggregated into a single, overarching BLMK STP. This will then be submitted to NHS England and NHS Improvement in June 2016. Once the STP is agreed, implementation of the constituent plans will commence.

Maintaining Performance

The Board of Directors recognises the importance of sustaining the level of delivery against national quality and performance targets delivered by the Trust in recent years. During the last year, the organisation has demonstrated an exceptional ability to maintain operational performance whilst also focusing on strategic planning and change. This will be particularly important in coming years.

Maintain and Develop Key Clinical Specialties

- Maintain key specialties to secure our future in terms of clinical excellence, financial sustainability and reputation.
- Develop clear strategies for key specialties to maximise the benefit from the re-organisation of acute services to the north of the Trust.
- Ensure that specialty plans give consideration to the 'necessary volume' to ensure give the economies of scale required for the delivery of seven day services and financial and clinical sustainability.

Explore Opportunities for Growth

- Explore the growth opportunities across the range of services offered as a consequence of the Bedford and Milton Keynes review, either alone or in partnership.
- Actively engage other stakeholders including the CCGs and the local authorities in rethinking models of community care embedding L&D expertise services in the heart of the major localities.
- Increase the Trust's market share in the services identified in the Clinical Services Strategy as offering greatest opportunity e.g. Cardiac Services, Stroke, Trauma and Orthopaedics, Spinal Surgery, Women and Children's, Bariatric and Ophthalmology.
- Explore opportunities for synergy with existing services e.g. the development of restorative dentistry to support maxillo-facial surgery
- Strengthen the relationship with tertiary hospitals to enhance and develop a range of hyper-acute services, in particular paediatrics, cancer, stroke and trauma.

Ensure Sustainability

- Continue to improve the patient experience and safety, for example, through improving communication and the provision of information to patients and greater access to consultant-led care.
- Ensuring the maximum use of information to deliver safe and efficient care by using an electronic patient record, and decision support information systems at all levels of the organisation.
- Ensure that the delivery achieved during 2015/16 against national and local quality and performance targets is fully embedded, further improved and maintained.
- Directing our capital resources at those service changes which will allow sustainability of performance.
- Maintain financial sustainability, delivering a comprehensive programme of efficiency projects which meet the need for tariff efficiency and the financing of the redevelopment programme.
- Embed the new structures in the medical and surgical divisions to allow greater focus at specialty level in order to benefit fully from service line management and bring forward a new generation of clinical leaders.
- Continue to review and strengthen performance by the use of internal and external expert review.

Corporate Objectives 2016/17

In 2014 -16 the Trust's Strategic Direction was underpinned by seven corporate objectives detailed in the Operational Plan. These objectives have been reviewed and objective 5 has been changed to reflect the changes to the strategic environment in relation to the Sustainability and Transformation Plans (STP).

1. Deliver Excellent Clinical Outcomes	• Year on year reduction in HSMR in all diagnostic categories
2. Improve Patient Safety	• Year on year reduction in clinical error resulting in harm • Year on year reduction in HAI
3. Improve Patient Experience	• Year on year improvement in patient experience demonstrated through hospital and national patient surveys, leading to upper quartile performance
4. Deliver National Quality & Performance Targets	• Deliver sustained performance with all CQC outcome measures • Deliver nationally mandated waiting times & other indicators
5. Implement our New Strategic Plan	• Deliver new service models in line with the emerging STP: – Emergency Hospital – Women & Children's Hospital – Elective Centre – Academic Unit • Implementation of preferred option for the re-development of the site in line with the emerging STP.
6. Secure and Develop a Workforce to meet the needs of our Patients	• Develop and monitor the delivery of a comprehensive recruitment programme for all staff groups. The programme will incorporate a work plan focusing on retention. • Ensure a culture where all staff understand the vision of the organisation and a highly motivated to deliver the best possible clinical outcomes. • Deliver excellent in teaching a research as a University Hospital. Ensure that all staff have access to appropriate education and facilities to maintain their competence.
7. Optimise our Financial Plan	• Deliver our financial plan with particular focus on the implementation of re-engineering programmes

Improving Quality

The Trust Quality Priorities are identified and reported in detail within the Quality Account.

Mortality and Complaints Boards

The Mortality Board and Complaints Board continued throughout 2015/16. Both meetings are chaired by the Chief Executive Officer (CEO) and have wide representation from divisions and also include Non-Executive Directors.

The Trust Mortality Board managed an action plan and:

- Completed detailed case reviews of areas of concern
- Initiated ongoing reviews of all patient deaths
- Arranged for an external review of our response to the elevated HSMR.

To date no major clinical issue has been identified, although a series of service changes are planned, some of which are already implemented to further improve the overall quality of care patients receive.

The Complaints Board continues to see improvements in the management of complaints by the Divisions. The divisions have continued to implement changes to the governance of complaints to manage the process and implement any learning.

Raising Concerns and Freedom to Speak Up Guardian

We have continued our focus on encouraging our staff to raise any concerns. During July 2015, the CEO followed up an initial letter she had sent in January 2015, and wrote to all staff asking them to tell her (confidentially) if they believe a patient has suffered harm or if there has been a near miss and they do not feel confident that the incident is being properly addressed.

National guidance has also been received that requires us to have a 'Freedom to Speak Up Guardian Role' that we need to have in place by the end of March 2017 and work began to develop proposals for implementation.

Engagement Events – 'between Good Better Best'

At the heart of L&D is a culture of staff ownership and involvement. This culture is nurtured by a comprehensive range of communication and engagement activities.

Particularly important was the large scale, trust wide 'Good, Better, Best' events where all staff came together to identify quality priorities and monitor progress in improving clinical outcome, patient safety and patient experience. The events also provided the opportunity to feedback learning from serious incidents and any action taken as a result of issues raised. It is planned to continue these events throughout 2016/17.

Compliance Manager

During 2015, we developed a key organisational role of 'Compliance Manager'. This role was pivotal to our on-going assessment of quality across the Trust in line with the CQC Core Standards and Key Lines of Enquiry. The role will continue to monitor compliance and ensure that we further develop systems and processes in order to maintain, further develop and enhance quality.

Transforming Quality Leadership 'Buddy' System

Building on the Compliance Manager role, we implemented a programme of quality reviews with the leadership team was implemented to assess quality across the Trust services. Leaders within the organisation were assigned a 'buddy' area and were required to complete weekly visits and escalate any issues. This process provided 'board to ward' reviews and also supported staff to raise concerns and issues to the management team. This programme has developed into a revised quality monitoring framework.

Revised On-going Compliance and Quality Monitoring framework

In March 2016, the Clinical Outcome Safety and Quality Committee agreed a revised On-going Compliance and Quality Monitoring framework.

We will implement an improved co-ordinated monitoring framework which is linked to the fundamental standards of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.

The components of the framework are already in place within the Trust, but the framework outlines how the following will be co-ordinated:

- Senior Manager Buddy link to clinical areas /checklist
- Peer Review Programme (both internal and external)
- Nursing and Midwifery quality and safety indicators (Harm Free Care / Nurse Sensitive Indicators / Safety Thermometer)

- Patient-Led Assessments of the Care Environment (PLACE)
- Friends & Family Test
- Non-Executive Directors walk round
- Patient Surveys (internal and external)
- Staff satisfaction surveys (externally led)
- Staff Appraisals
- Staff 1:1s
- Incident reports / Number of Serious Incidents
- Annual Full Inspection

The introduction of an annual CQC style **'Full Inspection'** of all wards and registered locations of the Trust will be conducted over the period of a week, using subject experts from all departments of the Trust (including cleaning and catering contractors). This inspection will result in each clinical area being awarded an annual rating to ensure that they are Safe, Effective, Caring, Responsive and Well Led. These ratings will be aligned to the CQC rating scale. (Outstanding, Good, Requires Improvement and Inadequate).

This will also be linked to a Nursing and Midwifery Ward Accreditation Award Scheme, which is currently being finalised. The programme will be on-going and will commence in April 2016, with our first 'Full Inspection' planned for October 2016.

We will use forums already accessible and committed to measuring the CQC standards which includes the annual PLACE inspection, Back to the Floor Friday (BTFF) as well as the information from audits undertaken on both a regular and ad hoc basis.

We will relaunch the internal Peer Review Programme implementing a new framework linked to the CQC's Key Lines of Enquiry (KLOEs) which will enable the reviewers to award a percentage aligned to a RAG rating. There will be a consistent approach throughout the Peer Reviewing Programme, all answers/evidence /observations on the framework measurable, we are currently developing a scoring system which will enable a final percentage score to be calculated and subsequently aligned to a rating category to each domain. Simple guidance, for the monitoring tool and the scoring system will be produced for all 'reviewers'.

We continually look to share best practice with others and we engage with other NHS organisations inviting them to visit the Trust once every six months.

Service Developments planned for 2016/17

Strategic and Corporate:

- **Implement Chemocare** – For us to be a recognised chemotherapy centre it is essential for the Trust to implement Chemocare, the chemotherapy prescribing system. The system has been scoped and will be implemented as part of the new approach and as such is a key priority for 2016/17.

- **Replace our eObservations platform and an electronic Version of the Take List** - We will continue to evaluate options for replacing these systems in line with the Technology Fund Monies that we have been awarded, and aim to have decided on the systems and implemented them by Q3 2016. Both systems are crucial to the safe operational management of our patients.

- **Review the procurement of a new pathology system** – The Trust is currently considering ways to enable us to provide a robust modern platform for our critical Pathology Service.

Surgical Division:

- **Continue to work on developing Specialist Vascular Services** - As part of the Trust's five year strategic plan, which is consistent with the emerging finding of the Health Care Review, re-establishing vascular services at the L&D was identified as a key opportunity to enhance and complete our hyper-acute portfolio. During 2015/16, the Surgical Division will be working in partnership with DTO to establish the operational model and viability of a full vascular service supported by interventional radiology. This will require the development of a comprehensive business case and work to identify any early enablers of such a development, such as the establishment of vascular lab services at the L&D to save patients having to travel to Bedford for their imaging prior to surgery.

- **Expanding the Acute Oncology Service** – following successful embedding of the Acute Oncology Service, the team is to be expanded to ensure service resilience across the week. This is an important part of the commitment to improving services for oncology patients particularly those who develop severe complications following chemotherapy. We are also working towards establishing an inpatient haemato-oncology unit within the hospital bed pool.

- **Developing Urology Services** – in 2015/16, the new Urology one-stop clinic facility opened, which enables patients to have their diagnostic tests at the same time as their consultation rather than having to come back at a later date. Recruitment is also planned for a substantive 5th Urologist and will be completed during 2015/16 which will enable the service to expand.

- **Redesign of the surgical pre-assessment processes** – In 2016/17 the division is investing in a significant improvement project to review and redesign the pre-assessment pathway and prevent patients having to be cancelled on the day of surgery, whilst optimising their pre-operative journey.

- **Establishing restorative dentistry services** – The division is working with colleagues in Specialised Commissioning to review the opportunity to establish restorative dentistry services as part of the Oral Maxillofacial Services (OMFS) hub and spoke model. This is an important aspect of the head and neck service portfolio, and enhances the level of specialist work carried out at the hospital. This development is being combined with expansion in OMFS and orthodontics as part of the OMFS service strategy.

- **Improving patient and family experience in End of Life Care** – The End of Life Care programme is being rolled out across the hospital and is an area of focus for the hospital 2016/2017, along with specialist palliative care service developments.

- **Continue to develop Specialist Palliative Care services** to support further improvements in the delivery of End of Life Care, and to adopt a whole system approach in developing a greater resilience in Consultant Palliative Care cover arrangements

- **Establishing inpatient Paediatric Orthopaedics services at the L&D** – The division is in the process of recruiting a new Paediatric Orthopaedic Surgeon in order to establish local services for paediatric orthopaedic surgery. We are working with the other divisions to develop new care pathways and also working to link with tertiary partners to ensure a resilient service model.

Medicine Division:

- **Develop support for performance monitoring and decision making** - Performance exception reporting, monitoring and decision making will be further supported in 2016/17 with the continued development of directorate dashboards and service line reporting. It is recognised the change in the divisional structure will need to ensure learning and integration across Medicine, and Trust wide.

- **Implementation of service line management/ reporting** - During 2015/16 the Division progressed linking operational and financial performance through service line reporting (SLR). During 2016/17 this will be further refined to better enable the leadership and development of services to support delivery of the best clinical and financial outcomes. SLR was integral to informing the decision to participate in the competitive tendering process for the provision of Integrated Sexual Health Services for Luton.

- **Commencement of Integrated Sexual Health Services for Luton Borough Council** On 1 October 2015 the L&D was awarded a five year contract (with a potential for a two year extension) for the provision of a fully integrated sexual health service for Luton. The contract was awarded by Luton Borough Council and commenced on 1 April 2016. Our innovative service model, aligned with National Strategy, has been developed to bring benefits to the community through the establishment of a purpose designed Luton town centre hub with additional clinics being provided across four locations in Luton. In addition to welcoming new staff from the previous service providers to assist with resourcing the new service model, the L&D will also make use of the latest sexual health services technology to enable direct appointment bookings and results messaging to our sexual health service clients. As the single provider in 2016/17 we will be monitoring and reporting on the effectiveness and quality of the services.

- **Continue the implementation of all case mortality reviews** – as part of the national and Trust strategy the division of medicine commenced all mortality case reviews from December 2015. The aim is to provide assurance that clinical care is safe and any deaths that have occurred due to service failure are identified and acted upon. This includes identifying contributing factors and themes for improvement and to increase awareness, reduce variability and share areas of best practice. In 2016/17 the challenge will be to ensure outcomes and learning are embedded across the directorates and Trust wide.

- **Continue Rheumatology service development** - This includes an increase in capacity for Paediatric Rheumatology, introduction of combined clinics for Interstitial Lung Disease, Psoriatic Arthritis and Ankylosing Spondylitis as well as increasing the research portfolio.

- **Remodel the Diabetes and Endocrinology out-patient service** – Following publication of the National Diabetes Inpatient Audit (NaDIA) which measures the effectiveness of diabetes healthcare against NICE clinical guidelines and NICE quality standards, the Directorate will compile an action plan to remodel the service. This will include the development of a Gestational Diabetes Mellitus Service to meet new diagnostic criteria.

- **Recruit an additional Inflammatory Bowel Disease Nurse** – An additional specialist nurse will be appointed in collaboration with the CCG to support patients with ulcerative colitis in commencing Biosimilar therapy.

- **Develop the Prosthetic and Orthotic service** – The service have a plan to implement electronic Primary Consultations and we are awaiting delivery of 'Cad Cam' funded by NHS England for Prosthetic socket and Orthoses design.

- **Further progress towards becoming a Hyper Acute Stroke Unit** - Stroke service improvement work will continue with the aim of becoming a regional Hyper Acute Stroke Unit.

- **Further develop the Ambulatory Care services** – During 2016/17, the Division will develop the Ambulatory Care services further through weekend opening, greater capacity and co-location with the Emergency Department.

- **Transition to a Needs Based bed model** - Continue to progress needs based model across the division. Successful implementation requires a fully integrated approach and recognition of all interdependencies including pathway redesign and workforce planning.

Women & Children's Division:

- **Extend the provision of community maternity services** – the Division is planning to expand the services at Ridgeway Court in Leighton Buzzard to include Ultra Sound Scanning and Obstetric clinics for women booked to deliver at LDH.

- **Provide community midwifery clinics into Hemel Hempstead and Redbourn** – Extending the clinic practices in Hemel Hempstead and Redbourn will support women's choice and promote normality in pregnancy and local support to women booked to deliver their baby at the L&D.

- **Enhance Foetal medicine services** – Enhancing Foetal Medicine will provide earlier support and advice to families experiencing complex pregnancy.

- **Increase resilience / capacity of Foetal Medicine service** – In order to ensure women have access to the Foetal Medicine services when they need them an additional consultant will be appointed and the infrastructure will be expanded.

- **Work collaboratively with Primary and Community partners** – working collaboratively the Division aim to increase services to better manage and prevent obesity in children. This will also provide specialist clinics and improved awareness of obesity throughout the paediatric service.

- **Re-establish parent and child involvement groups** – these groups will provide specialist support and general drop-in opportunities for feedback and engagement in service developments. These developments build on the success of specialist support days run by Epilepsy and Diabetes teams.

- **Continue collaborative work with local CCGs, Primary and Community paediatric services** – on-going collaboration will further support safe alternatives to admission and monitor their impact on the children and families.

- **Continue to improve facilities for families** – The Neonatal team plan to create a parents' sitting room, improved and breast feeding and expressing facilities on the unit. In addition, the service will also provide counselling and psychological support for families.

- **Improve facilities for assessment and discharge on the gynaecology ward** – By improving the facilities on Ward 34, the Division aim to enhance patient experience and support a reduction in the patient's length of stay.

- **Continue to develop local specialist fertility and IVF provision** - in partnership and as a satellite unit of Bourn Hall, Cambridge, the Division will continue to develop the fertility services provided at the hospital.

- **Further optimise use of theatre sessions** - through collaborative working with the Surgical Division the Division aim to further optimise the theatre sessions and aims to move gynaecology lists from the maternity theatres.

- **Collaborative working with Surgical Division to support the resilience and further development of local Children's surgery** – The Division plan that by hosting admissions and providing paediatric support, further resilience can be achieved in the provision of surgery for children. The Division also aims to further develop shared training and collaboration with the anaesthetic team to support increased surgical pathways and high dependency care including shared training initiatives.

- **Collaborative working with Medical Division**– the Paediatric Team aim to further improve pathways for sick children in Children's ED by working closely with the Medical Division and to also further enhance care of Diabetes in pregnancy in line with new guidelines

- Further develop transitional pathways – through collaboration with all Divisions, the paediatric team will aim to improve transition pathways to adult care for young people with long term conditions and disability.

Diagnostics, Therapeutics & Outpatients Division:

- **Trust wide roll out of partial booking** – Following the successful pilot of partial booking in several clinical specialties in Medicine and Surgery in 2015/16, the Outpatient team will be implementing a roll out programme by specialty across the Trust. Partial booking, combined with the expansion of patient choice in the scheduling of appointments via 'invite to call', will reduce Did Not Attend (DNA) rates across the Trust, and as integral to Outpatient re-engineering, will improve efficiency and patient experience.

- **LIMs implementation** – The Pathology department has successfully completed the procurement stage of the Laboratory Information Management System (LIMS), and will progress implementation during 2016/17. This is a very substantial undertaking which will bring benefit to Pathology, the wider Trust and GP services in improving business intelligence, results analysis and facilitate future service developments.

- **Development of new Therapies Hub** – Integral to the Hospital redevelopment programme, a new Therapies Hub will provide centrally located facilities for Physiotherapists, Occupational Therapists and Speech and Language Therapists to provide therapy interventions to both inpatients and outpatients.

- **Develop Cardiac MRI and SPECT-CT** – Expanded MRI service development and repatriation of cardiac MRI will enable patients to access a more specialist Imaging locally, enhancing the range of diagnostics and rapid intervention for patients across several clinical pathways.

- **Develop a level 2a Haemato-oncology unit** – In line with the recommendations of the Haemato-oncology peer review conducted in 2015, the Division

is developing the service model for a dedicated and specialist unit to best manage the needs of acutely ill patients with haematological cancers and sickle cell disease. This will enable a wider cohort of patients to access specialist services and chemotherapy locally, supported by an infrastructure and delivery model to achieve service accreditation.

- **Support the development of Needs Based Care in Medicine** – Services across DTO including Pharmacy, Therapies and Dietetics will be reconfiguring to best support the introduction of Needs Based Care in Medicine, looking to optimise and align resource to enhance patient care and new clinical pathways.

- **Mortuary refurbishment** – The Trust is currently working with the Coroner's office and local Borough Councils to develop plans for the refurbishment of an expanded Mortuary to support both the needs of the hospital and local community. This will enable the decommissioning of the Auxiliary store, facilitate hospital redevelopment plans and provide a fully integrated and combined mortuary and bereavement service.

Operational performance report

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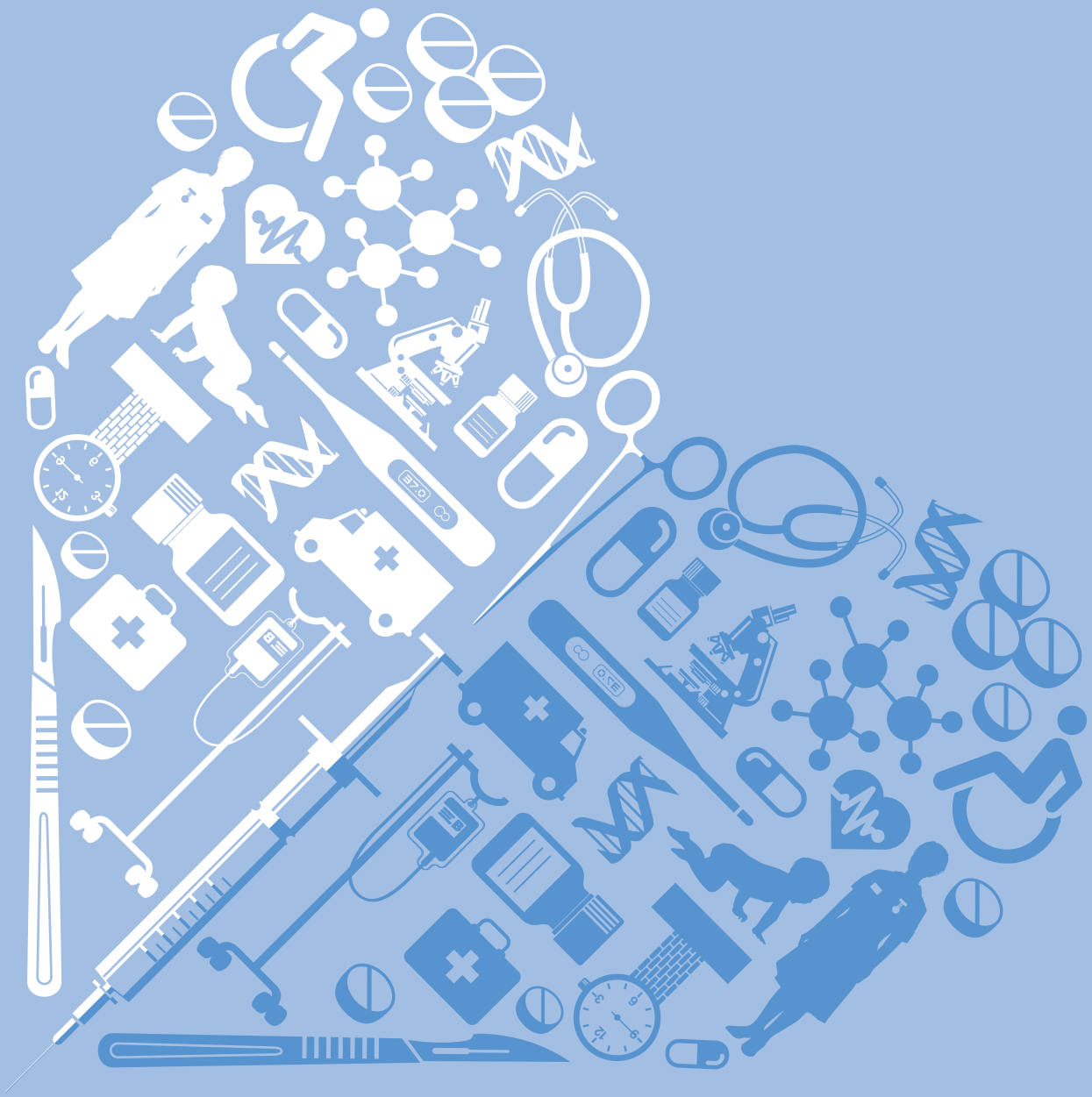


Principal activities of the Trust

The Luton and Dunstable University Hospital NHS Foundation Trust is a medium size general hospital with approximately 660 inpatient beds. The hospital provides a comprehensive range of general medical and surgical services, including Emergency Department (ED) and maternity services for people in Luton, Bedfordshire, Hertfordshire and parts of Buckinghamshire. Last year we provided healthcare services for over 90,000 admitted patients, nearly 400,000 outpatients and Emergency Department attendees and we delivered over 5,300 babies.

We serve a diverse population most of whom are the 210,000 people in Luton (Luton Annual Public Health Report 2013/14). Luton is an ethnically diverse town, with approximately 45% of the population from non-white British communities (Luton Borough Profile 2011 census data). Within this group there are significant Pakistani, Bangladeshi, Indian and African Caribbean communities. We celebrate the diversity of our population and are committed to ensuring that issues of equality and diversity have a high profile. There are particular healthcare challenges in an area with high levels of ethnicity. The 2010/11 Luton Annual Public Health reports states that in many cases, Black and Minority Ethnic (BME) communities have poorer health outcomes when compared to the overall population and these are linked to infant mortality, access to services due to awareness, language and cultural barriers, early onset dementia and diabetes.

The L&D has developed a range of specialist services including cancer, obesity, neurophysiology and oral maxillofacial (jaw) surgery. We have the responsibility for treating the most premature and critically ill newborn babies across the whole of Bedfordshire and Hertfordshire in our tertiary level Neonatal Intensive Care Unit (NICU). We also have one of the country's largest breast screening centres.

All inpatient services and most outpatient services are provided on the Luton and Dunstable Hospital site. The Trust provides community musculo-skeletal services (MSK) at three locations across the catchment area, including our new Orthopaedic Centre situated further along Dunstable Road and chronic obstructive pulmonary disease (COPD) and Diabetes services for South Bedfordshire.

The Trust has a strong and robust clinical management culture; all clinical services are managed by Clinical Chairs, Divisional Directors, supported by Clinical Directors, General Managers and Senior Nurses.

Division	Specialties		
Medicine	Emergency Department Acute Medicine Ambulatory Care Elderly Medicine Limb Fitting Stroke Service General Medicine	Respiratory Medicine Diabetes and Endocrinology Gastroenterology Cardiology Dermatology Heptology Neurology	Neurophysiology Orthotics Genito Urinary Medicine Rheumatology Obesity
Surgery	General Surgery - Colorectal - Upper Gastrointestinal - Vascular - Bariatric Surgery Urology Paediatric Surgery	Trauma & Orthopaedic Hospital at home Critical Care Plastic Surgery ENT Cancer Services Medical Oncology	Ophthalmology Oral & Maxillofacial Surgery Anaesthetics Pain Management Orthodontics Audiology
Women and Children's	Obstetrics Community Midwifery Early Pregnancy General Gynaecology	Gynae-oncology Paediatrics Fertility Neonatal Intensive Care Unit	Uro-gynaecology Ambulatory Gynaecology
Diagnostics, Therapeutics & Outpatients	Pathology Services - Blood Sciences - Cellular Pathology - Microbiology - Phlebotomy Haematology Care	Pharmacy Physiotherapy and Occupational Therapy Imaging Musculoskeletal Services Dietetics	Speech & Language Therapy Clinical Psychology Outpatients Breast Screening

During 2015/16 Divisional Directors, General Managers and Executive Directors met in the Executive Board.

In September 2015, we implemented new governance structures in the Division of Medicine and the Division of Surgery. Clinical Chairs for each division were appointed and monthly Executive Meetings established with each of the Clinical Divisions to increase clinical accountability at specialty level.

Other Executive meetings are dedicated to the Clinical Operational Board that reviews the clinical performance of the Trust and Re-Engineering programmes that focuses on the quality improvement programmes and efficiency.

For detailed information on related parties see note 27 to the accounts

Review of Operational Performance

Key performance targets 2015/16

We assess our own operational performance against external national targets published by the Care Quality Commission (CQC), the Monitor (NHS Improvement) Risk Assessment Framework and other locally agreed contracts, with the support of external peer review and other external expertise.

Activity

- During 2015/16, the L&D continued to consistently deliver against national quality and performance targets, achieving a Monitor governance rating of green throughout the year.

In addition, the L&D:

- Was the only Trust in the country to achieve the emergency care 4 hour national target every week despite experiencing both a high volume of Emergency Department attendances and an increase in admissions.
- Met or improved upon the national standards for patients not waiting more than 18 weeks for treatment from the point of referral in all quarters.
- Met all of the cancer targets for the year with the exception of the 2 week wait for breast symptomatic breast patients in Quarter 2. This was due to the temporary closure of another local unit which resulted in unexpected volumes of patients. The position was recovered in the following quarter and overall the Trust has delivered one of the best cancer performances in the country.
- Had excellent performance for C Difficile maintaining a low rate of 11 (one of the lowest in the country and below the diminimus of 12) but this did exceed the agreed contract threshold of 6.
- Reported 1 MRSA Bacteraemia which is also under the diminimus of six for reporting to Monitor.

The table on next page summarises how our operational performance described above is interpreted against the national objectives by CQC and Monitor.

L&D Performance against CQC and Monitor Targets

	Threshold				
Total time in A&E - ≤4 hours (Whole site %)	95%	Q1	Q2	Q3	Q4
All cancers: 31-day wait for second or subsequent treatment (3), comprising either:					
Surgery	94%	Q1	Q2	Q3	Q4
anti cancer drug treatments	98%	Q1	Q2	Q3	Q4
radiotherapy	94%				
Cancer: two week wait from referral to date first seen (7), comprising either:					
all cancers	93%	Q1	Q2	Q3	Q4
for symptomatic breast patients (cancer not initially suspected)	93%	Q1	Q2	Q3	Q4
All cancers: 31-day wait from diagnosis to first treatment (6)	96%	Q1	Q2	Q3	Q4
All cancers: 62-day wait for first treatment (4), comprising either:					
from urgent GP referral to treatment	85%	Q1	Q2	Q3	Q4
from consultant screening service referral	90%	Q1	Q2	Q3	Q4
Referral to treatment waiting times – Incomplete pathways	92%	Q1	Q2	Q3	Q4
Clostridium Difficile – meeting the Clostridium Difficile objective of no more than 6 cases/year	6 (12 diminimus)	Q1	Q2	Q3	Q4
MRSA – meeting the MRSA objective of no cases/year	0 (6 diminimus)	Q1	Q2	Q3	Q4

Achieved Not Achieved

Quality

CQC Performance

The Care Quality Commission (CQC) is the organisation that regulates and inspects health and social care services in England. All NHS hospitals are required to be registered with CQC in order to provide services and are required to maintain specified 'essential standards' in order to retain their registration.

As part of its role the CQC is required to monitor the quality of services provided across the NHS and to take action where standards fall short of the essential standards. Their assessment of quality is based on a range of diverse sources of external information about each Trust that is regularly updated and reviewed. This is in addition to their own observations during periodic, planned and unannounced inspections. If an issue raises concern during the data review process or from other sources of information, CQC may undertake an unplanned, responsive inspection.

The Luton and Dunstable University Hospital NHS Foundation Trust is fully registered with the CQC and its current registration is **Registration without Conditions.**

No enforcement action has been taken against the Trust during the reporting period April 1st 2015 and 31st March 2016 and we have not participated in special reviews or investigations by the CQC during the reporting period.

CQC Assessments

The CQC monitor, inspect and regulate care services to ensure patients receive safe, effective, compassionate, high quality care. To really measure the patient's experience of care, they have identified five key questions based on the things that matter to patients. The CQC will ask these questions of every service.

- **Are they safe?** By safe we mean people are protected from physical, psychological or emotional harm. For example are people getting MRSA because of poor hygiene?
- **Are they effective?** By effective we mean that people's needs are met and their care is in line with nationally recognised guidelines and relevant NICE quality standards or effective new techniques are used to give them the best chance of getting better. For example is there an effective 'enhanced recovery' programme?
- **Are they caring?** By caring we mean that people are treated with compassion, respect and dignity and that care is tailored to their needs.
- **Are they responsive to people's needs?** By responsive we mean that people get the treatment and care at the right time without excessive delay.
- **Are they well-led?** By well led we mean that there is effective leadership, governance (clinical and corporate) and clinical involvement at all levels of the organisation and an open, fair and transparent culture that listens and learns and that there is a clear programme of improvement.

The Care Quality Commission's team of inspectors visited the hospital over three days in January 2016 and carried out two further unannounced inspections to formally inspect and assess the quality of the care the trust provides. We are expecting the report in May 2016.

We have in place a CQC self assessment programme for all wards and clinical areas. This involves a three month cycle of self assessment, peer assessment and external peer assessment to support the delivery of performance and the implementation of corrective action in a timely manner. We have reviewed our CQC assessment programme to reflect the revised CQC inspections and these assessments are reported to each Board of Directors meeting.

Non-Executive Assessments (3x3)

The assessment process is further enhanced by Executive and Non-Executive Directors participating in our 3 x 3 initiative. The 3 x 3 initiative requires them to spend 3 hours every 3 months in a clinical setting working with staff to review their performance against CQC standards.

Transforming Quality Leadership 'Buddy' System

We implemented a programme of quality reviews with the leadership team to assess quality across the Trust services. Leaders within the organisation were assigned a 'buddy' area and were required to complete weekly visits and escalate any issues. This process provided board to ward reviews and also supported staff to raise concerns and issues to the management team. It also supported a key part of the Trust preparation for the CQC inspection. This programme has developed into a revised quality monitoring framework.

Quality of Governance

We have ongoing monitoring of quality governance through the committee structure which is detailed in the Governance section of this report. Further information about how we review quality is contained within the Quality Account section of this report. Assurance in relation to our Assurance Framework and internal control is contained within our Annual Governance Statement.

Regulatory Performance Ratings

NHS Improvement (previously known as Monitor), which regulates all NHS Foundation Trusts, allocates risk ratings for each quarter against their risk of breach of authorisation as a Foundation Trust.

NHS Improvement monitored the Trust during 2015/16 using their Risk Assessment Framework.

The risk rating for the Risk Assessment Framework are:

1. Continuity of Service risk rating

The continuity of services risk rating incorporates two common measures of financial robustness:

(i) **liquidity:** days of operating costs held in cash or cash-equivalent forms, including wholly committed lines of credit available for drawdown; and

(ii) **capital servicing capacity:** the degree to which the organisation's generated income covers its financing obligations.

A rating of 1, 2, 2*, 3 or 4 is assigned where 1 represents the highest risk and 4 represents the lowest risk.

2. Governance risk rating

Governance ratings are derived from a number of elements including:

- Performance against nationally selected outcomes and standards
- CQC compliance
- Relevant information from third parties

Trusts are then rated red, amber or green regarding compliance with governance arrangements where red is taking regulatory action.

The Risk Assessment Framework assessment criteria that Monitor apply can be found at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/455893/RAF_revised_25_August.pdf

Further information related to the L&D can be found at: https://www.gov.uk/government/publications/nhs-foundation-trust-directory/nhs-foundation-trust-directory

For 2014/15 and 2015/16 the Trust maintained a green governance rating and a continuity of services rating of 4.

Summary of rating performance

1. Comparison between 2014/15 and 2015/16:

	Annual Plan 2015/16	Q1 2015/16	Q2 2015/16	Q3 2015/16	Q4 2015/16
Financial risk rating	4	4	4	4	4
Governance Risk Rating	Green	Green	Green	Green	Green

	Annual Plan 2014/15	Q1 2014/15	Q2 2014/15	Q3 2014/15	Q4 2014/15
Financial risk rating	4	4	4	4	4
Governance Risk Rating	Green	Green	Green	Green	Green

2. Trust performance against national targets

National Target	Q1 2015/16	Q2 2015/16	Q3 2015/16	Q4 2015/16
CQC Action	No	No	No	No
Monitor override	No	No	No	No

We had no formal interventions.

Activity Performance Analysis

The table below identifies those areas where demand has changed by comparing the actual contracted activity to that planned.

Activity Type	Units	2015/16 Plan	2015/16 Forecast	2016/17 Plan
Activity - Acute & Specialist				
Elective inpatients	Spells	35,167	35,354	38,503
Non-Elective	Spells	50,830	54,656	56,672
Total Admitted Patients		**85,997**	**90,011**	**95,175**
Outpatients - first attendance	Attendances	88,765	77,121	83,878
Outpatients - follow up	Attendances	153,220	160,798	177,960
Outpatients - procedures	Procedures	44,993	53,624	56,724
Total Outpatients PbR Tariff Only		**283,897**	**291,543**	**318,563**
A&E	Attendances	**98,274**	**93,525**	**98,447**
Maternity Pathway		**10,845**	**11,045**	**11,267**
Critical Care				
Adult - Intensive Care	Bed Day	2,416	2,457	2,559
Adult - High Dependency Unit	Bed Day	2,697	2,556	2,662
Adult - Ward Based High Dependency	Bed Day	2,730	1,355	1,753
Neonatal -Intensive Care	Bed Day	2,269	2,475	2,578
Neonatal -High Dependency Unit	Bed Day	2,859	2,801	2,917
Neonatal -Special Care Babies	Bed Day	6,728	5,675	5,910
Neonatal -Transitional Care	Bed Day	1,173	1,289	1,343
Paediatric - High Dependency	Bed Day	1,882	2,640	2,750
Total Critical Care	**Bed Day**	**22,754**	**21,248**	**22,470**

In 2015/16 our commissioners anticipated substantial CIP reductions. Despite their endeavours planned reductions on activity did not occur and emergency activity, in particular, has shown a significant increase in non-elective work and outpatient attendances even though there was a slight reduction overall in A&E attendances, there was a significant increase in the latter stages of the financial year.

The Hospital performed well to accommodate this unplanned activity without compromising a range of national target indicators increasingly utilising services such as hospital at home and ambulatory care to absorb the demand. However, this activity could not be provided within existing employed staffing levels, consequently the Hospital incurred substantial temporary staffing costs.

Research Performance

Ongoing clinical excellence at the L&D is supported by high quality research and a robust evidence base. The Trust's aim is to undertake high quality research that addresses issues of concern to the local population and to the NHS as a whole. High quality research provides the evidence with which to practise 'evidence based-medicine'.

The current NHS Five Year Forward View states that:-

'Research is vital in providing the evidence we need to transform services and improve outcomes. We will continue to support the work of the National Institute for Health Research (NIHR) and the network of specialist clinical research facilities in the NHS. We will also develop the active collection and use of health outcomes data, offering patients the chance to participate in research; and, working with partners, ensuring use of NHS clinical assets to support research in medicine'.

The Trust's research strategy emphasises strengthening research through collaboration with the Department of Health funded UK Clinical Research Network (UKCRN), the National Institute for Health Research (NIHR) in England via the Clinical Research Networks (CRNs), local Clinical Commissioning Groups and Academic links. We are a member of **CRN: North Thames** whose remit is to provide researchers with the practical support to facilitate clinical studies in the NHS and increase research across England.

This practical support includes:

- Reducing the "red-tape" around setting up a study.
- Funding the people and facilities needed to carry out research "on the ground" so research activity does not drain core NHS resources.
- Helping researchers to identify suitable NHS sites to recruit patients to take part in research studies.
- Advising researchers on how to make their study "work" in the NHS environment.

With the increase in funding from CRN North Thames, allocated to employ additional research nurses, the Research & Development Department, in addition to its usual workload of research governance, study set up and study approvals, has been very busy supporting the various specialty departments to appoint the research nurses. The following specialty departments include Neurology, Paediatrics, Ophthalmology, Gastroenterology / Hepatology, Respiratory Medicine, Microbiology / Infectious Diseases, Musculoskeletal (Rheumatology and Orthopaedics) and Reproductive Health and Childbirth. In addition to this allocation of funding, CRN North Thames has provided shared research nurses in non-malignant Haematology (shared with UCL) and Diabetes (shared with West Herts.).

Recruitment to NIHR Portfolio studies at the L&D for 2015/16 totals 710 patients. In CRN North Thames the bar is set high in respect of recruitment and quality but we are confident we are up to the challenge particularly with the additional research nurses. The Trust looks forward to the L&D becoming one of the best recruiting DGHs – if not the best – in CRN North Thames.

Research issues and studies approved to be undertaken at the Trust (via the Research & Development Department) are presented at the quarterly Division of Medical Education and Research (DMER) Committee meetings. There are currently 123 active research studies in which 40% of our consultants are involved.

The NIHR Central Commissioning Facility publish a Performance Analysis Report on 'Peformance in Initiating and Delivering Clinical Research' for each quarter of the year. Within this Report the Luton and Dunstable Hospital is assigned to League 5 *.
(* the Leagues are based on the number of absolute trials for continuity with previous reports and to ensure fair comparison between similarly sized providers').

Q1 Report (September 2015) states:

League 5 – Summary
'Five providers in League 5 had 100% of adjusted trials meeting the benchmark: Luton and Dunstable University Hospital NHSFT (7 of 7) ..... The provider with the lowest mean duration between Valid Research Application and NHS Permissions was Luton and Dunstable University Hospital NHSFT with 0.9 days .....'

Q2 Report (January 2016) states:

League 5 – Summary
'As in the previous quarter, the provider with the lowest mean duration between Valid Research Application and NHS Permissions was Luton and Dunstable University Hospital NHSFT, this time with 0.6 days'.

The Trust's Annual Academic Report for 2015/16 will be available in September 2016. However, the Annual Academic Report for 2014/15 reported that, in addition to the 143 ongoing research studies during that year, publications by Trust staff included 87 Scientific Papers; 51 Abstracts and 13 Books or Chapters in Books.

Education and Performance

Medical Education

Medical Education has remained a high priority for us during 2015/16. We have strengthened the governance supporting both undergraduate and postgraduate training.

Undergraduate

Our undergraduate medical training continues to develop and increase in the number of clinical specialties supporting studies. We continue to receive high satisfaction rating from UCLH students both for the placement but also the support during preparation for exams. We have appointed two new Directors of Undergraduate Training who have made a positive start and have some exciting ideas for the future.

Postgraduate

We are committed to ensuring that the quality of training for postgraduate medical and dental trainees delivers the requirements of the curriculum. During 2015/16, we hosted Health Education East of England LETB (School) visits for Acute Medicine, Obstetrics and Gynaecology and Anaesthetics. The feedback from the visits is outlined below. There was also a Quality Performance Review (QPR) visit in July 2015 which covered both medical and non-medical educational performance and overall the visit was positive with some recommendations that are being developed.

Medicine

A new College tutor was appointed to work alongside the existing Director of Education for Acute Medicine. The Tutors continue to work closely with a Trust steering group to provide support to the trainees and enhance training provided. The Medicine and GMC Joint visit at the end of the year was positive with recognition of the significant improvement to the trainee experience and acknowledgment of the further work still to be undertaken.

Obstetrics & Gynaecology

In March 2015 the Post Graduate School of Obstetrics and Gynaecology revisited the Trust and were very pleased with the significant progress the team had made against the requirements. There was a marked improvement in the trainee feedback which again was reflected later in the year through the GMC Survey.

The department continues to make improvements with close working relationships with the Clinical Directors, College Tutor and the Trust transformation team. A revisit by the School is planned for 2016, date to be confirmed.

Anaesthetics

The Post Graduate School of Anaesthetics visited the Trust at the end of November 2015. Overall the visit was positive with a small number of recommendations. These have been actioned and a revised action plan has been completed. A revisit is planned for the end of 2016.

Pre-Registration Education for Nurses and Midwives

We currently provide clinical placements for pre-registration nursing and midwifery students. The quality of placement standards is monitored yearly via a qualitative and quantitative assessment through the Quality Improvement Performance Framework (QIPF). This framework is monitored quarterly against an action plan to ensure continuous improvement. All placement areas are reviewed yearly against placement audits. Our performance against this assessment is good and we strive to meet all the requirements of the regional Learning and Development Agreement.

Also, student feedback on both the Higher Education Institution and the Trust placement is used to review placement areas. Each student, depending on year, is allocated a qualified mentor. Third year students on final placement are allocated sign off mentors who are responsible for signing them off to go on to the Nursing and Midwifery Council (NMC) register. To monitor quality, we undertake a formal assessment of the performance of the University of Bedfordshire and the University of Hertfordshire using nursing education quality indicators as a benchmark. Annually, 160 nurses and 60 midwives are trained in partnership with the University and the Trust.

Pre-Professional Workforce

We have complied with proposed national changes to the education and training of this group of staff based on recommendations from the Cavendish Report. It has been agreed that all clinical support staff will undertake the Care Certificate to ensure an improvement in knowledge and skills for the benefit of patients. If they do not currently hold a recognised Health and Social Care qualification, we have opted to use the apprenticeship model to deliver this training and this covers the curriculum specified in the Care Certificate.

Appraisal and Pay Progression

We have implemented pay progression in line with revised national Agenda for Change requirements introduced in 2014. Incremental pay progression is now dependent on staff having had an appraisal within the

last 12 months, compliance with core mandatory training, and achievement of individual objectives.

We have seen a steady increase in core mandatory training compliance in 2015. Our appraisal compliance rate continues to fluctuate slightly but remains around 80% with long term sickness, maternity leave or service pressures leading to appraisals having to be rescheduled as the primary reasons for late completion. Appraisal rates are monitored on a monthly basis and managers are informed of compliance so that they can take action in a timely fashion including advising staff that their pay progression will be prevented due to non-compliance with corporate requirements.

Personal and Continuous Professional Development

We continue to undertake an annual training needs analysis which informs our bid for regional funds for Continuing Professional Development. This also complements discussions at appraisal when individual personal development plans are developed with staff. We published our comprehensive training brochure which covers a wide range of programmes include statutory training; health and safety, clinical skills, leadership and management development, communication skills and IT training even earlier in 2015 which enabled managers to roster their staff onto training in a more timely fashion.

In recognition of the national move towards a more blended approach to learning, we continue to provide access to an excellent resource for leadership and management development through the Ashridge Business School. All staff can access the Virtual Ashridge website through the Intranet. We also promote e-learning and provide supported sessions for staff to undertake their mandatory training, where appropriate.

To ensure that registered staff update their knowledge and skills, they attend higher education modules at three universities contracted to deliver courses through Health Education East of England. In addition, staff continue to access specialised courses linked to their professional development at appropriate centres of excellence nationally.

We have renewed our licence for the European Computer Driving Licence (ECDL) so that we can train, assess and examine staff to achieve the qualification. There has been a steady stream of applicants over the year which enhances our overall IT literacy as an organisation. Looking ahead, we are investigating the option of replacing this approach with an apprenticeship qualification in information technology which would be a more cost-effective and flexible option and would fit our overall strategy to increase the range of apprenticeships we offer.

A Special Mentoring Scheme

In the last 18 months, we have partnered with Luton Sixth Form College to deliver a mentoring programme for a group of Year 12 students keen to pursue a career in medicine. The students have had meetings with their mentors to introduce them to what it is like to work in the hospital, advise them on the application process for medical school and prepare them for interviews as well as increasing their confidence. There was also an opportunity to meet a Medical Director and have some interview practise. All five are on track to successfully complete their academic studies and have had interviews for places at a wide range of universities including Oxford.

Overseas Nurses

Since April 2014 we have recruited 120 EU nurses of whom 87 remain in the Trust.
They all have a tailor-made induction programme over 3 weeks which incorporates assessment of their prior learning and skills and time on their wards. The nurses then have the preceptorship competencies to complete which assesses their knowledge and skills in practice.

All EU nurses now have to provide evidence to the Nursing and Midwifery Council that they meet the English language requirements they set. It is only once these are met that their registration proceeds. To ensure that all the nurses have a reasonable standard of English, they are assessed at interview as part of the screening process prior to submitting their documentation to the NMC. We are once again offering English classes to prepare some of our existing staff who require professional tuition to pass their IELTS (International English Language Testing System). This will enable them to proceed with their registration with the NMC.

Apprenticeships

From 01.04.15 to 31.01.16 the Trust has enrolled 77 new learners to an apprenticeship qualification, against a target of 70 for this financial year. Currently the Trust has 137 staff enrolled to an apprenticeship. The L&D were the first Trust in the East of England to offer Management Level 5 Apprenticeship qualifications, and on the momentum built by the success of the first cohort, cohort two will commence in April 2016.

The Trust continues to broaden the range and level of apprenticeship qualifications that we are engaged in, and

to offer apprenticeship qualifications at levels 2,3,4 and 5. The L&D is one of the most proactive Trusts in the East of England.

Leadership Development

We continue to participate in NHS Leadership Academy national programmes although the introduction of fees has restricted the numbers of managers who can attend. We are actively promoting any available opportunities to all our managers, both clinical and non-clinical, and the talent management process we are introducing should facilitate the identification of future leaders across the Trust.

The 'Leading Safe and Effective Quality Patient Care' programme is continuing with further groups of Ward Managers and specialist nurses and midwives. The package on offer includes the option of external coaching through a regional coaching network in Bedfordshire and Hertfordshire.

We are working on our approach to clinical leadership development further with a customised programme for newly appointed consultants and senior doctors in a medical management role. Following some in-depth consultation with a range of senior medical stakeholders, we are planning a number of opportunities including mentoring, coaching, workshops, master classes and one-to-one personal development to support doctors working in a challenging leadership role.

The NHS Healthcare Leadership Model continues to be promoted internally and we have increased the number of feedback facilitators in the Trust. Uptake of the 360° feedback model is increasing as staff see the benefit of receiving in-depth feedback on their performance as managers and leaders. This has a positive impact on the culture of the organisation.

Coaching takes place regularly for senior staff, where appropriate and helpful, and we are developing our approach to Health Coaching so that we can support patients with long-term conditions to manage their health in collaboration with their clinician. We now run our own internal Health Coaching programme for clinicians and have trained over 20 staff across specialities.

Medical Revalidation

There are 363 doctors within General Medical Council (GMC) Connect who have identified the Trust as their designated body for Revalidation. All doctors are supported to prepare for their individual revalidation with the GMC which is required every 5 years. We provide access to 360° feedback at least once in 5 years and doctors have automatic access to a customised website to prepare for their appraisal each year. This online web-based portfolio of evidence is a full record of the doctor's whole practice and provides comprehensive information towards revalidation.

Our main focus is to ensure that doctors are made aware of their responsibilities and can confidently prepare for and successfully go through the revalidation process. We have successfully achieved the numbers for each quarter and are confident that we are on target for doctors employed by the Trust.

Sustainability/Climate Change Performance

Introduction

As an NHS organisation, and as a spender of public funds, we have an obligation to work in a way that has a positive effect on the communities we serve. Sustainability means spending public money well, the smart and efficient use of natural resources and building healthy, resilient communities. By making the most of social, environmental and economic assets we can improve health both in the immediate and long term even in the context of rising cost of natural resources.

In order to fulfil our responsibilities for the role we play, L&D has the following sustainability mission statement located in our sustainable development management plan (SDMP):

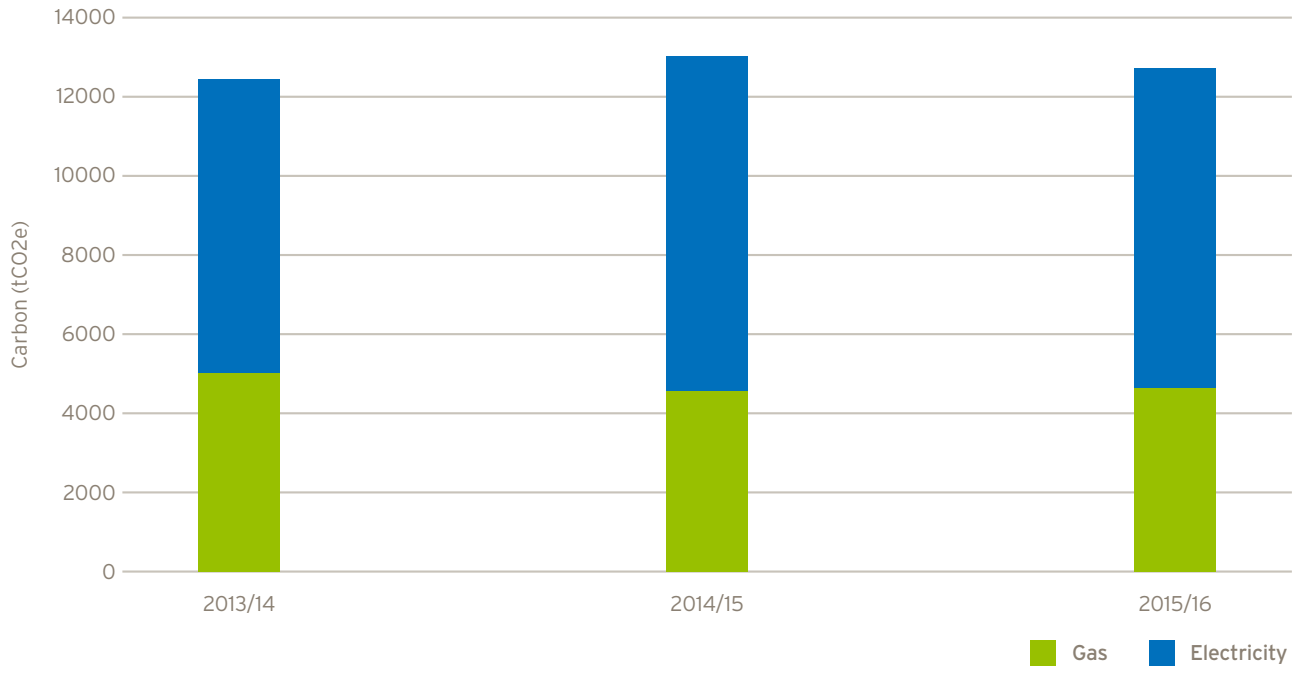
- To comply with, and exceed where practicable, all applicable legislation, codes of practice and other requirements to which the Trust subscribes
- To integrate sustainability considerations into all our business decisions
- To reduce the environmental impacts of all our activities
- To prevent pollution
- To review, annually report, and to continually strive to improve our sustainability

Performance

As a part of the NHS, public health and social care system, it is our duty to contribute towards the level of ambition set in 2014 of reducing the carbon footprint of the NHS, public health and social care system by 34% (from a 1990 baseline) equivalent to a 28% reduction from a 2013 baseline by 2020. It is our aim to meet this target by reducing our carbon emissions 28% by 2020 using 2013 as the baseline year.

Energy

Carbon emissions - energy use



Power and heating is supplied to the Trust via the consumption of electricity and gas. Both are measured in kWh.

The consumption of both utilities is influenced by the seasons and has remained fairly constant over the last three years with minor reductions due to boiler improvements and the fitting of LED lighting.

The slight reduction in gas consumption may have been due to a combination of factors:-

- milder weather – the number of heating degree days below 18.5oC was less than last year.
- effect of the boiler plant dry cycling technology introduced in the summer

The overall electricity consumption has seen a slight increase over the last year however there is a slight reduction in the carbon emissions from the electricity consumed due to the fact that our service provider produces 16.3% of the electricity from renewable resources.

Year	2013 / 2014	2014 / 2015	2015 / 2016
Degree Days	3080	2983	2897

Gross expenditure on the CRC Energy Efficiency Scheme to cover emissions generated in 2015/16 is £180,000.

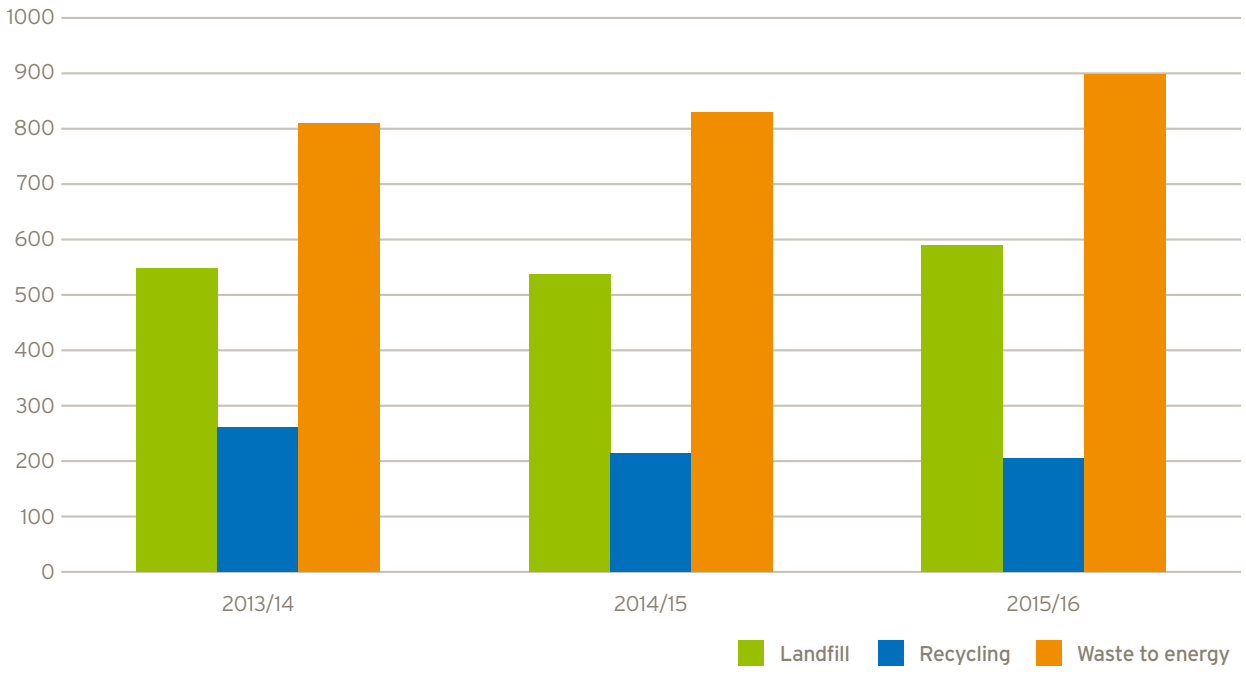
The measures employed to improve energy performance of the estate have to some degree offset the recent developments which have increased the operating footprint of the site – such developments include:-

- change of use for existing buildings on the retained estate
  - St Mary's Wing
  - Urology Clinic
- expansion of the retained estate with new operating theatre suite and
- new orthopaedic centre located in Dunstable Road

Waste

Overall the amount of waste produced by the Trust is in line with the increased clinical activity. With recent refurbishment projects there has been a separate exercise to de-clutter wards by removing surplus equipment. Wherever possible such items are re-cycled or put to alternative use.

Waste production (tonnes)

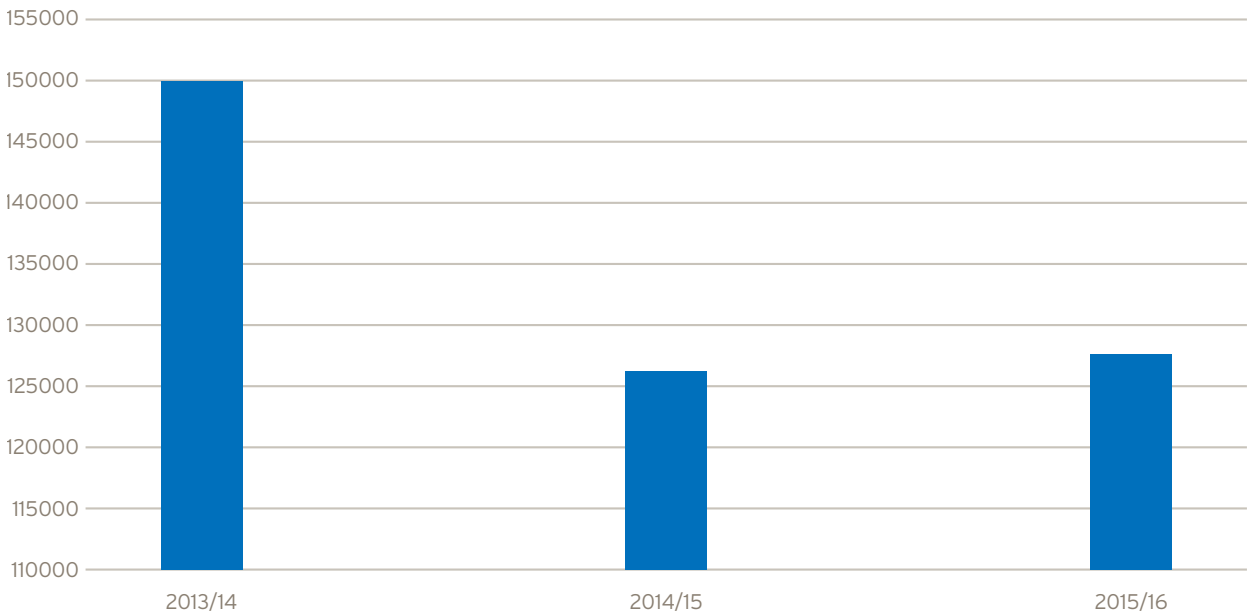


Overall waste production has increased, with infectious or offensive waste that is incinerated and utilised for waste to energy increasing most.

Landfill has increased which is likely to be due to a large amount of refurbishment work and relocations.

Water

Consumption (m^3)



2014/2015 saw a marked reduction in water consumption due to the fixing of leaks and the installation of some water saving measures.

2015/2016 shows a comparable water usage with only a slight increase despite the additional activity levels.

We aim to have automatic meter readers (half hourly) put on all the incoming water supplies so that they will allow water leaks to be detected even earlier and should facilitate calendar month billing rather than the mechanism currently in place.

Transport

The hospital travel plan has been reviewed as part of the overall site redevelopment strategy. Staff, and patient and visitor travel surveys have completed as part of the transport assessment and travel plan revision.

In anticipation of a number of early works schemes, additional offsite staff car parking has been made available at Skimpot Road.

We have continued to develop our partnership working with Arriva bus and Luton Borough Council with several promotions around the Luton Busway. Our long-standing discount bus ticket promotion with Arriva continues to be popular this recently enhanced with the introduction of the Arriva APP with the discount being extended to day tickets.

Carbon Management Plan implementation

In February 2015, a successful bid for £30,000 loan from the SALIX fund to procure enhanced controls in 4 Boiler house plant rooms. The simple but proven technology, reduces dry cycling within the boilers so that they only operate when there is a genuine call for heating from the system and not just to keep the water hot within the boiler. The installation was completed on 31 March 2015 and we are now in the 12 month post project evaluation period. The project feasibility study suggested a saving of 178 tonnes of carbon dioxide equivalent to a consumption saving of just under 1,000,000 kWh of gas. Project payback is anticipated at just over one year.

Further energy efficiency measures which been introduced over the last financial year include replacement of old lighting across a number of wards and corridors with LED high efficiency light fittings complete with controls.

Looking Forward

The main energy and sustainability savings to be made in the forthcoming years will be delivered by the hospital redevelopment plan as old estate is replaced with new energy efficient buildings or significantly refurbished.

Energy centre

As part of the development plan an Energy Centre is planned that will replace the old and inefficient distributed boilers around the Trust with a central boiler house. This will also create the opportunity to generate its own electricity using a combined heat and power (CHP) system.

Improved controls

Planned upgrade of Building Management Systems (BMS) controls to ensure that all heating and ventilation plant operation is optimised and reduces energy consumption.

Energy efficient equipment

Further replacement of old lighting installations with newer energy efficient LED systems will continue, especially where wards and departments are earmarked for refurbishment and wherever possible any replacement electrical equipment will be more efficient than the item it replaces by using the latest technology available.

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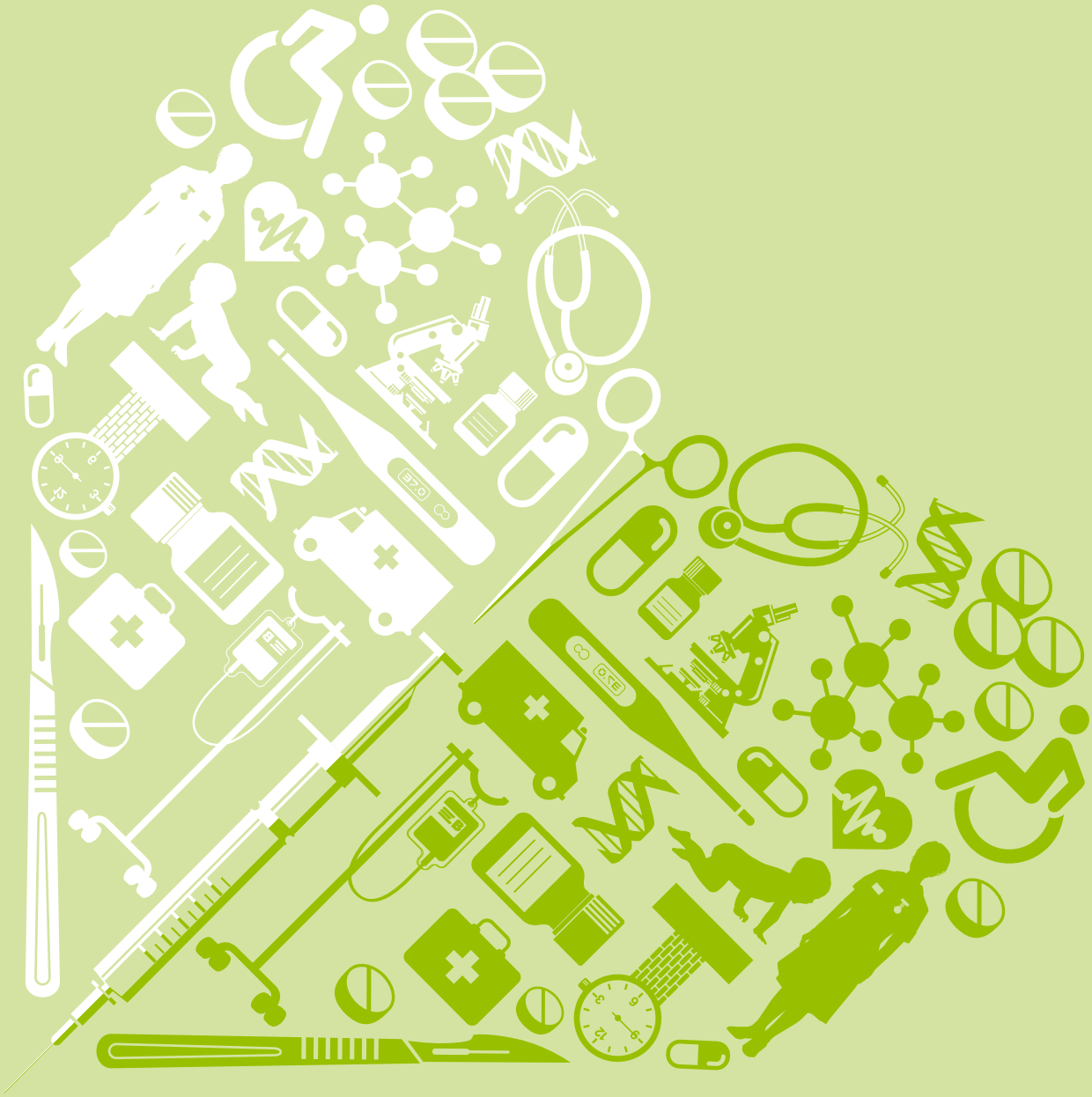


Our Patients

We continue to collect feedback from our patients across all our services. The Friends and Family Test (FFT) is an important part of this feedback and provides clinical areas with a percentage recommend score. Wards display their latest recommend score on the Quality and Safety Information Board shown in figure 1. The wards also provide a 'You Said' comment with a response' We Did' to inform patients and visitors of the improvements that are being made as a result of their feedback.

The Paediatric Wards have been using both the feedback from the FFT and the 2015 National Children's' and Young Person's survey to drive improvements in communication. The wards have introduced "My Daily Plan" sheets for each patient identifying who their doctor and nurse and the child's care plan for the day. This is being piloted on Ward 24 with a plan to use this across wards, 25, 26 and 26a. This will support staff to encourage good communication across the department while supporting parents to ask questions for when the Nurses and Consultants do their rounds.

Figure 1 Quality and Safety Information

Patient Experience Call Centre and Patient Advice and Liaison Service (PALS)

If patients, families or carers have any concerns about their care or treatment then the PALS staff are available to help and if requested will visit patients on the wards to help with any immediate problems. PALS can signpost to other services and arrange meetings with staff to resolve issues on the spot. The PALS desk is located in the main entrance of the hospital within the Patient Experience Call Centre and is open from 9am to 5pm with a drop in facility from 10.00 to 12.00 and 14.00 – 16.00 Monday to Friday with a message service available out of hours.

Welcome booklets, PALS and Complaints leaflets are now available via the website for patients in other languages. Staff continue to contact patients by telephone to complete both the FFT and a further survey. Volunteers and Governors support staff in making these calls.

Local Involvement Networks Healthwatch

Healthwatch Luton completed a survey of our inpatients in January and February 2015, the results of the survey were received by the Trust in October 2015. Healthwatch reported that it was 'positive to report that 84 per cent of patients scored their overall inpatient experience as good or excellent'. A number of recommendations were made to which we have already made some progress to improve such as extending our visiting times and seeking to improve the quality of catering and cleaning through an outsourcing programme.

Patient and Public Participation Group

During 2015/16 the Patient and Public Participation was reviewed. A focus group was held in February 2016 to gain ideas for refreshing the group membership and to discuss the purpose of the group. During this meeting a review of the draft Patient and Carer Experience and Public Involvement Strategy took place with feedback from the 26 people who attended.

The Trust held two Public and Patient feedback events in July where people attending could talk directly to divisional mangers and senior members of staff. In February a group of 15 Asian women who attend English classes at a Luton community centre attended a meeting to find out more about our services and how to book an interpreter if required.

Listening to Patient Concerns

We treat all complaints seriously and ensure they are handled in accordance with the Health and Social Care Complaints Regulations. During the reporting period we received 595 formal complaints. A breakdown of complaints (by month, by category) is contained within the Quality Account.

All the complaints were thoroughly investigated by the General Manager for the appropriate division involved and a full and honest report was sent to the complainant.

The majority of complainants were resolved at local resolution level. Some of the meetings were headed by the General Managers and some meetings were with the Medical Director or the CEO. However, 12 complainants asked the Parliamentary and Health Service Ombudsman (PHSO) to review their complaints. Following this process, five complaints have been investigated and a final report has been done, two are waiting for a decision and five are being investigated by the Ombudsman.

The data collated throughout the year highlights that there is further action that needs to undertaken to improve consistency of achieving the timescales for responding to complaints. However, the quality of the investigations being carried out and the standard of those responses remain very high.

We have made improvements to our complaints process, for example:

- If people are not happy with their response they are invited to come for a Local Resolution Meeting to discuss their concerns.
- We are sending our questionnaires with all our responses for patient feedback.
- Patient Affairs completes a weekly update and this includes the overdue complaints for every division and therefore this is escalated to senior managers.

Compliments

During the reporting period over approximately 6,500 compliments were received directly by the staff or service, and cascaded to the staff and/or service involved by the respective manager. This is an increase of 1,500 from the previous year.

Below are some of the compliments we received recently:

"I came to A&E on Sunday morning 21st February 2016 with chest pains. From the moment we arrived we were treated fantastic by superb staff who all acted calm and professional which straight away calmed me down and put me at ease I was seen very quickly and given a full check- up. The doctor and nurse who cared for me were first class can you pass on my thanks to them unfortunately I cannot remember their names I think the staff do a fantastic job."

"I would like to thank you for the kind and caring treatment I received at the breast screening unit."

"My son has recently been in for an operation and I wanted to say a massive thank you to the staff in the hedgehog ward on the 8/02/2016 and all the staff who looked after him in the ground floor theatre. I can't put into words how amazing everyone was on that day with me being a nervous wreck. Thank you all so much."

"I visited the A&E dept today after having a coughing episode and passing out and damaging rib tissue. I would like to commend the Triage nurse and two doctors who examined and treated me. They were friendly, extremely efficient and a credit to your hospital and the NHS. I hope my thanks can be passed on to the dept."

"I would just like to say that I went into hospital on the 22/12/15 for a hysterectomy. He [the consultant] did a fantastic job and the nurses on ward 34 were great! I had barely any pain afterwards and am so happy I went through the procedure. Many thanks for all that your staff did for me."

"I have just had to stay on ward 21 for two nights and the care was first class a hard working team that were kind compassionate and professional. Restored my faith in the NHS."

"[The patient] was admitted to your hospital in November 2015 and died on ward 14 on the 15th November. I wanted to thank all the staff on this ward for the incredible care and compassion they showed to him in his last weeks. It was a great help for those of us who loved him to know he was in such good hands. We knew he wouldn't be allowed to suffer or feel uncomfortable. All the staff were first class - genuinely caring and highly competent. The cleaning staff worked so hard and were also so friendly and interested in how we were doing. We were all so impressed with everyone connected with this ward; I do hope you will pass on this email to them. We won't forget what they did."

The Chaplaincy Service

This has been another successful year for the Chaplaincy team as we have continued to grow with many new volunteers joining the team, giving us the opportunity to develop the care and support we are able to offer patients, visitors and staff whilst in the L&D.

Over this past year we have been able to support over 2,000 patients and staff each month. We now have over 60 volunteers, involved in ward visiting and helping with the Chapel services alongside organists, flower arrangers and a calligrapher. We are currently working with Voluntary Services and the Palliative Care Team to develop a new volunteer role offering a supportive presence to those at the end of their lives.

We have been delighted to welcome two of Luton's Imams to the team who are offering, as volunteers, support to patients and their families as well as being able to support staff in their care of our patients. This is a part of the ongoing development of the partnership of care between the Chaplaincy and the communities and faith communities we serve.

We have also just launched an appeal, with the help and support of the L&D Charitable Fund, to raise £30,000 to enable us to redevelop the hospital chapel, The Chapel of St Barnabas. We want to improve the facilities and environment for the many people from many faiths who use the Chapel as a place of worship, prayer or quiet reflection.

Our Staff

Our success is delivered through our people and as such our staff continue to be our most valuable asset when it comes to delivering clinical excellence, quality and safety to our patients. We strive to achieve this through many different routes, including delivery of learning and development; good leadership and good communication. This journey starts from the point that an individual applies for a post with us and continues through their employment with the Trust.

Recruitment

In recent years we have been particularly busy in terms of the recruitment of staff both clinical and non clinical. This has continued throughout 2015/16 where we advertised 1018 posts advertised that resulted in 946 new starters (excluding bank starters, staff transferring from bank to permanent posts and existing staff being promoted).

The Trust put a particular emphasis on the recruitment of Registered Nurses and Health Care Assistants and below we set out some of the work that we have been doing.

Registered Nurse Recruitment

As well as continuing to recruit locally by recruiting newly qualified student nurses and holding bi-monthly recruitment open days. We have also looked nationally and have been proactive in participating in Recruitment Fairs in Scotland, Belfast and Dublin.

The Trust has also looked further afield in Europe (Portugal, Italy and Spain) as well as campaigns in India and the Philippines.

Health Care Assistants (HCAs)

Throughout the year bi-monthly HCA recruitment campaigns have been held and these have resulted in 115 HCAs commencing in post. We have also held additional open days for some speciality campaigns, for instance Theatres HCAs.

The development and progress of HCAs is monitored through completion of the induction Care Certificate competencies within 12 weeks of commencing at the Trust. This baseline competency programme is a national requirement for all care workers. For care assistants without a level two qualification as part of their employment, 54 HCAs have commenced a Clinical Apprenticeship in General Healthcare following on from their induction. This contributes greatly to the employer's apprenticeship targets set by Health Education East of England HEEoE).

The Foundation Degree, (FD) is the qualification required of our Assistant Practitioners (AP) currently being employed in specialist areas of the trust and more recently on general elderly care wards. From the September 2015 intake, we have three completing the foundation degree. APs are skilled up to the first year of a Student nurse academically with four or more years of practical experience having completed level two and three general healthcare qualifications. The medical division have now employed eight new APs across the wards.

The FD, plus Maths and English at level two is also the entry requirements for those who wish to undertake the new Flexible Nursing Pathway being developed in partnership with the University of Bedfordshire, HEEoE and local service providers including the L&D. For the flexible nursing pathway students can work towards a nursing degree and study alongside the traditional three year students. Students are required to work for three days per week in their normal role and undertake the requirements of the nursing programme on the other two days per week. The students are jointly funded by the employer and the HEEoE. In March 2016, five of our staff have commenced this exciting new programme.

Sickness Absence Project

The sickness absence project has been running for just over two years during which time we have seen a significant reduction in sickness absence levels across the Trust.

The project has delivered a cultural shift towards managing sickness absence with a more proactive action orientated approach being adopted by line managers to address sickness absence caseloads. This has included coaching and training of line managers and also delivering the message that sickness absence management is for all employees. In addition, it has reached across other areas to change the culture within the Trust realigning mindsets and behaviours, including Recruitment & Resourcing, ensuring that the right people are recruited with the right skill set for the right positions with the appropriate controls and processes.

As a result of this focus, the Trust has one of the lowest sickness absence rates of any acute Trust in the East of England and one of the leading Acute Trusts across NHS England when it comes to sickness absence rates.

We are now moving into a phase of sustainability and continuing to embed the principles of absence management whilst ensuring that absence is continually managed through meaningful dialogue and in line with the Trust policy

Staff Engagement and Consultation

The L&D takes pride in having a healthy and productive relationship with staff and this is reflected in the staff engagement scores in the Staff Opinion Survey, where this year was again higher than the national average. In addition, the Trust scored in the top 20% of Trusts across the country with 73% of staff reporting that they were able to contribute towards improvements at work, good, communication between senior management and staff was also found to be above (better than) average.

Staff Recognition

There have been a number of opportunities over the year to thank staff and volunteers for their contributions. In particular:

- In recognition of their long service, staff were invited to an awards event at Luton Hoo Hotel in February 2016 supported by the Charitable Fund. This was the Trust Board's way of thanking staff who made a significant contribution to the Trust over the last 25 years. The event was enjoyed by all who attended and many happy memories were shared in respect of service over the years.

During National Volunteers week held in June 2015, we arranged a day trip to the seaside for our volunteers, which was a very enjoyable day. A further event was held in in January 2016 where 80 volunteers enjoyed an afternoon at the Pantomime at a local theatre.

Communicating and engaging with our staff

The Trust recognises that communicating and engaging with our staff is a key part of our success. Feedback from the 2015 Staff Survey showed that the Trust scored above average for its overall staff engagement score. Similarly, we scored above average for the percentage of staff reporting good communication between senior management and staff.

Having a committed and engaged workforce contributes directly to the quality of the care we provide to our patients. Messages are delivered in a variety of ways both within individual teams and department and across the Trust as a whole.

Examples of staff communications and engagement include:

- Weekly face-to-face staff briefings are led by our Executive Team, where we share information on key operational issues
- The Non Executives and Governors were proud to be able to thank all staff for their hard work during a walkabout in February 2016
- Established local newsletters are in place across divisions, departments and wards to share good practice and learning within teams
- A fortnightly newsletter is sent to all nursing staff, which includes information on patient safety issues. During the coming year, we are working to broaden the scope of this newsletter to include other groups of clinical staff
- A bi-monthly newsletter is sent to all Trust staff, developed by the Staff Involvement Group, which includes stories from staff about health and wellbeing and the contributions they make to the Trust and our local community
- Key time-sensitive messages are cascaded to all staff via our intranet and email systems
- Regular meetings are held with senior leaders in our clinical divisions to share information with and receive feedback from frontline colleagues
- Our Trust Board meets monthly with our Council of Governors, which includes eight elected staff governors

Staff governors actively speak directly to colleagues to gather their thoughts and ideas about how to improve working lives at the Trust

- The Joint Staff and Management Council (JSMC). This is a meeting of staff side representatives and senior managers of the Trust. The meeting is used to develop and consult on policies and any other matters that affect staff. The staff side JSMC representatives have been particularly supportive in the implementation of many initiatives where there has been a workforce implication, including providing support on change management consultations with staff. Regular meetings are held with senior managers and the Human Resources team to engage in discussion over formal consultations.

Staff Involvement Group

The focus of this group is on developing a culture of staff involvement, open communication and partnership working with factors that have a real impact on staff such as reward and recognition, security, health and wellbeing. The membership of the group is diverse and members are active in taking forward themes from the staff opinion survey and 'testing the ground' with staff initiatives to improve the patient experience.

Engagement events 2015

During the summer of 2015, over 68% of all Trust staff attended a series of engagement events hosted by the Chief Executive, during which staff from all departments identified the aspects of their working lives that they are most proud of, along with the key issues they wanted the Trust to take action on in their areas. These events were a direct response to feedback from staff in 2014, when our Chief Executive asked all staff via a survey and face to face meetings for feedback on improving communication.

As a result of the positive feedback received from staff a further engagement event was repeated during a week in December 2015, where a similar number of staff attended. The December events included detailed feedback from the summer events, with a comprehensive booklet given out to every attendee, as well as information to support staff in the lead up to our Care Quality Commission inspection in January 2016.

During the December events, we asked staff to list the top two strengths of their team and the Trust, as well as two areas where we needed to make improvements and how we were doing this. This information was shared with all teams for their individual areas in advance of the CQC inspection. Overall feedback was positive and constructive, as shown in the following summary.

Things our staff are proud of:

- The patient is at the heart and centre of all we do every day
- Patient feedback is excellent and most patients have a good experience
- Staff work well together in teams and across teams to support each other and to ensure the patient always has a good experience
- The Trust is collaborative and innovative
- Teams are good at communicating with one another
- Managers and senior leaders are visible and available
- The Trust is a good place to work and our culture and clinical reputation help attract new staff

Things our staff feel we need to improve on:

- Availability of specific equipment
- Availability of space to provide services
- Having sufficient time to complete training and on-going development
- Overall recruitment of staff

Staff Involvement Group Newsletter

The newsletter is produced every two months and is full of articles and stories for staff, by staff and about staff. The aim is for staff to be involved in something that is purely for them, and is a method for individuals to share their stories such as personal achievements, smoking cessation, weight loss, hobbies/interests or a new fitness regime that could inspire others to take action to live healthier lifestyles.

Our Volunteers

Volunteers play a vitally important role in the NHS, providing a variety of services alongside paid staff. Their time, commitment and skills, provide a positive and human element to patient care, and their contribution enhances the levels of service we are able to provide. All new volunteers attend a comprehensive induction and undertake training to be able to carry out their roles safely and effectively. We are very fortunate to have a dedicated and diverse team of 262 volunteers in a variety of roles within the Trust.

Age (years)	% of volunteers
Over 60	61.08%
40 to 59	18.7%
25 to 39	11.45%
18 to 24	8.77%

29.77% per cent are from a BME background, which is slightly under representative of our local community.

During 2015/2016, 87 new volunteers were recruited and there were a total of 77 Leavers. Of the other volunteers who left during this period, six went on to health related education, using volunteering as an insight into a healthcare setting and gaining valuable experience to enhance their CV and support University applications. The Trust has gained some national positive recognition for its Voluntary Services. In September, the Voluntary Service Manager, Karen Bush received an 'Excellence in Voluntary Services Management' Award from NAVSM (The National Association of Voluntary Services Managers) She received a Special Commendation for her innovative work in engaging young people and external community groups to support patients with dementia.

Pam Brown, ex Volunteer Governor was honoured at the Luton & Bedfordshire Community Awards in October. She received an 'Exceptional Achievement Award' for the outstanding contribution she continues to make to our hospital and patient care. Not only does she volunteer with us, but she also fundraises.

New services and roles this year include our Family and Friends volunteers who assist with obtaining patient feedback. We also now have hospitality volunteers in the eye clinic for which we have received public thanks in the local press, and volunteer support in the New Urology One Stop Clinic.

We held our annual Long Service awards event in December which was attended by 17 Volunteers and their guests. The awards were presented once again by Clifford Bygrave, former Non-Executive Director. This year it was lovely to see a number of staff join us to celebrate with Sham Bhagrath who has been volunteering here for 25 years.

Health and Wellbeing/ Occupational Health

We offer a full range of Occupational Health and Wellbeing Services which contribute to increasing the effectiveness of the organisation, by enhancing staff performance and morale through reducing ill-health, absence and accidents.

During 2015/16 the Trust has continued with and also introduced initiatives to promote opportunities for staff to adopt a healthier lifestyle either onsite or by promoting external facilities that are conducive to good health.

The Occupational Health and wellbeing Service has focused on providing information on health promotion topics and activities, by acting as a signpost for staff to obtain information and advice on a variety of health and fitness related initiatives. This has been achieved through the continued development of a health and wellbeing section on the staff intranet, various electronic communications, e.g. newsletters, and awareness raising events.

In June 2015, the annual health and wellbeing awareness raising day entitled 'Spring into summer' took place, which proved to be very popular. Awareness raising stands and activities included: smoking cessation, Livewell Luton promoted personal health plans, smoothie bikes, Heights/weights and Body Mass Index, sexual health advice, healthy eating, a nutritionist performing health snacks demonstrations, Active Luton held Zumba taster sessions and other keep fit demos, and Team beds and Luton workplace challenge promoted table tennis, amongst other initiatives. There was also a stand raising awareness around prevention of bullying and harassment with staff being encouraged to make pledges in support of good behavior at work. A similar event is currently being planned for 2016.

As a follow up from the above event, in July a number of teams comprising of Trust staff took part in Team Beds and Luton workplace challenge where a friendly, yet competitive game of rounder's took place.

This year, 57.3% of our frontline staff were vaccinated against flu, which was a higher uptake than the national average amongst other NHS Acute Trusts.

The Wednesday walking activity (30 minutes of a brisk walk) that has been running for a number of years has pepped up a little this year with the help of Active Luton, introducing us to a Nordic Walking taster session.

The Occupational Health team were successful in retaining their accreditation under the Safe Effective Quality Occupational Health Service. (SEQOHS). The SEQOHS Accreditation Scheme is a stand-alone scheme managed by the Royal College of Physicians of London which leads and manages the process on behalf of the Faculty of Occupational Medicine.

SEQOHS accreditation is the formal recognition that an Occupational Health Service provider has demonstrated that it has the competence to deliver against the measures in the SEQOHS Standards. The scheme was developed for all Occupational Health Services and providers across the UK in the NHS and Independent Sector.

Fruit and Vegetable Market Stall

Following on from a staff suggestion, a fruit and vegetable vendor was asked to set up a stall in an effort to promote healthy eating primarily to staff, but this has also been welcomed by patients and visitors. This was put in place in September 2015, and it has been well received.

2015 NATIONAL STAFF SURVEY SUMMARY OF RESULTS.

The 12th National Staff Survey was undertaken between September and December 2015. All Trusts are required to participate in the survey using a random sample of staff and the data from which is used by the CQC for the Benchmark Reports across all NHS Acute Trusts.

This year the Trust opted to survey a sample survey of 850 staff. Questionnaires were distributed in paper format only. We chose this method, because last year we opted for a mixed mode approach of email and paper questionnaires and our response rate dipped to 35%.

Completed questionnaires were sent directly to the Trusts independent survey contractor, Quality Health, for

analysis by age, staff groups and work and demographic profile.

This report gives a high level overview of the survey findings. A summary report of the complete results is available on the Trust intranet.

The survey report provides vital feedback from staff about working in the Trust. As in previous years, there are two types of key finding:

- Percentage scores, i.e., percentage of staff giving a particular response to
- one, or a series of survey questions.
- Scale summary scores, calculated by converting staff responses to
- particular questions into scores. For each of these summary scores, the
- minimum score is always 1 and the maximum score is 5.

Response Rates

2015 National NHS Staff Survey		2014 National NHS Staff Survey		TrustImprovement
Trust	National Average*	Trust	National Average*	
49%	41%	35%	42%	14%

* Acute Trusts

The official sample size for our Trust was 850. 404 completed questionnaires were returned. 16 members of staff returned their questionnaires without filling them in.

A group of 26 staff were excluded from the official sample as ineligible. E.g. having left the Trust or on long term sick leave.

There was a 14% increase in the response rate.

Staff Engagement

The survey measures overall Staff Engagement and the Trust scores are detailed as follows:

	2015 National NHS Staff Survey		2014 National NHS Staff Survey		Change since 2014 Survey	Ranking, compared to all acute Trusts
	Trust	National Average	Trust	National Average		
Overall Staff Engagement	3.84	3.79	3.78	3.74	No significant change	Above (better than) average
KF 1 Staff recommendation of the Trust as a place to work or receive treatment	3.81	3.76	3.70	3.67	Increase (better than)	Above (better than) average
KF 4 Staff motivation at work	3.94	3.94	3.89	3.86	No significant change	Average
KF 7 Staff ability to contribute towards improvements at work	73%	69%	73%	68%	No significant change	Highest (best) 20%

Key Findings

A summary of the key findings from the 2015 National NHS Staff Survey are outlined in the following sections:

Top Ranking Scores

Top 5 Ranking Scores	2015 National NHS Staff Survey		2014 National NHS Staff Survey		Change since 2014 survey	Ranking, compared to all acute Trusts
	Trust	National Average	Trust	National Average		
KF 6 % of staff reporting good communication between senior management and staff	35%	32%	34%	30%	No significant change	Above (better than) average
KF 7 % of staff able to contribute towards improvements at work	73%	69%	74%	68%	No significant change	Highest (best) 20%
KF 12 Quality of appraisals	3.31	3.05			No comparable previous data	Highest (best) 20%
KF 13 Quality of non-mandatory learning or development	4.08	4.03			No comparable previous data	Highest(best) 20%
KF 30 Fairness and effectiveness of procedures for reporting errors, near misses and incidents	3.76	3.7			No comparable previous data	Above (better than) average

Other Key Findings that scored above or below (better than) average

- KF 9 - Effective team working
- KF 14 - Staff satisfaction with resourcing and support
- KF17 - % of staff suffering work related stress in last 12 months
- KF23 - % of staff experiencing physical violence from staff in last 12 months
- KF28 - % of staff witnessing potentially harmful errors, near misses or incidents in last month
- KF29 - % of staff reporting errors, near misses or incidents witnessed in the last month
- KF30 – Fairness and effectiveness of procedures for reporting errors, near misses and incidents

Bottom Ranking Scores

Bottom 5 Ranking Scores	2015 National NHS Staff Survey		2014 National NHS Staff Survey		Change since 2014 survey	Ranking, compared to all acute Trusts
	Trust	National Average	Trust	National Average		
KF10 Support from immediate managers	3.64	3.69	3.7	3.65	No significant change	Below (worse than) average
KF 11 % of staff appraised in the last 12 months	81%	86%	88%	85%	Decrease (worse than)	Below (worse than) average
KF 15 % of staff satisfied with the opportunities for flexible working patterns	46%	49%			No comparable previous data	Below (worse than) average

KF 16 % of staff working extra hours***	75%	72%	77%	71%	No significant change	Highest (worst) 20%
KF 27 % of staff/colleagues reporting most recent experience of harassment, bullying or abuse	31%	37%	46%		New KF with newly calculated 2014 comparison	Below (worse than) average

*** Whilst KF 16 is an amalgamation of both paid and unpaid hrs, a further breakdown indicates the following:-

Response –unpaid extra hours	National	L&D	Response –paid extra hours	National	L&D
0 hours per week	42%	37%	0 hours per week	66 %	57 %
Up to 5 hours per week	45%	50%	Up to 5 hours per week	18 %	21 %
6 – 10 hours per week	9%	8%	6 – 10 hours per week	9 %	13 %
11 or more hours	4%	4%	11 or more hours	7 %	9 %

Other Key Findings that scored above or below (worse than) average

- KF 18 - % of staff feeling pressure in the last 3 months to attend work when feeling unwell
- KF20 - % of staff experiencing discrimination at work in the last 12 months
- KF24 - % of staff/colleagues reporting most recent experience of violence
- KF25 - % of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months
- KF26 - % of staff experiencing harassment, bullying or abuse from staff in last 12 months
- KF32 – Effective use of patient/service user feedback

Where Staff Experience has improved (largest change since 2014)

Improvements	2015 National NHS Staff Survey		2014 National NHS Staff Survey		Change since 2 014 survey	Ranking, compared to all acute Trusts
	Trust	National Average	Trust	National Average		
KF 1 Staff recommendation of the organisation as a place to work or receive treatment	3.81	3.76	3.70	3.67	Increase (better than)	Above (better than) average

Where Staff Experience has deteriorated (largest changes since 2014)

Deteriorated	2015 National NHS Staff Survey		2014 National NHS Staff Survey		Change since 2014 survey	Ranking, compared to all acute Trusts
	Trust	National Average	Trust	National Average		
KF11 - % of staff appraised in the last 12 months	81%	86%	88%	85%	Decrease (worse than)	Below (worse than) average
KF27 - % of staff/colleagues reporting recent experience of harassment, bullying or abuse	31%	37%	46%		New KF with newly calculated 2014 comparison	Below (worse than) average

The Staff survey results for 2015 are positive. We maintained an above average staff engagement score and also demonstrated an improvement in Staff recommendation of the organisation as a place to work or receive treatment.

We are extremely proud that the quality of non-mandatory learning and development and quality of appraisals are within the highest (best) 20% of Trusts, and despite the survey findings indicating that the percentage of staff being appraised in the last 12 months appears to be below average we know that our most recent actual statistics demonstrate that we have achieved the highest rate that the Trust has ever seen.

On the whole we are very pleased with the outcomes within the Staff survey, but acknowledge that there are areas where further action is required. Feedback is provided to all of the Divisions and as a result action plans are developed to support improvements in the areas required.

Equality and Diversity

During 2015/16 the Equality Objectives and Five Year Work Plan 2015 – 2020, and Equality, Diversity and Human Rights Strategy were finalised and published on the Trust website.

A survey forming part of our approach to grade how well the Trust is performing as part of the NHS equality framework was sent to local stakeholders. Alongside the survey staff and patient groups were asked to an Equalities Forum at the end of November where attendees were asked to grade the hospital on their experiences at the Trust. The results of this work and the grading awarded were published on the Trust's website in January 2016 and informed the actions within the Equality Objectives and Five Year Work Plan 2015 -2020.

The Trust increased the number of staff who signed up to become 'Personal Fair and Diverse Champions'. Further work is planned to engage with these members of staff in supporting Equality and Diversity values within the workforce.

Equality and Diversity face to face training is presented through the Trust induction with an e-learning module as part of the mandatory training. A programme of face to face training with staff in the work place has been planned with some sessions already delivered.

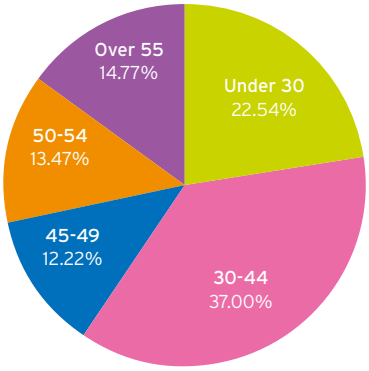
Opportunities for engaging with the community have been explored. A visit from a group of Asian women who are attending English classes was facilitated, giving the women an opportunity to meet staff and gain information about how to access services. The Equality and Diversity Lead has been available at focus groups held and a public engagement event in the summer months. The Learning Disability Coffee Mornings have been a valuable way to gain feedback about patient experiences.

We are working towards strengthening the Trust's Equality, Diversity and Human Rights Committee and are now guided by the Equality, Diversity and Human Rights Strategy.

2016 Annual Report – Equality and Diversity Graphs – using employee data as at 31st March 2016.

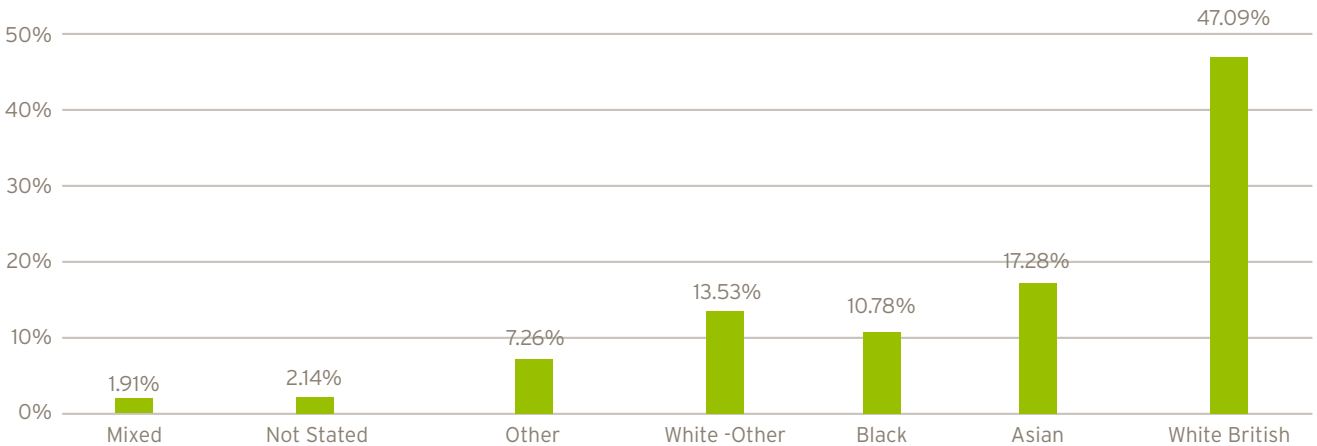
There is very little change in the age profile of the workforce from 2014 – 2015 with the majority of staff falling between 30 and 54 years old. The challenge for the Trust remains the significant proportion of staff in the over 55 age range who may opt for retirement.

Workforce by age band



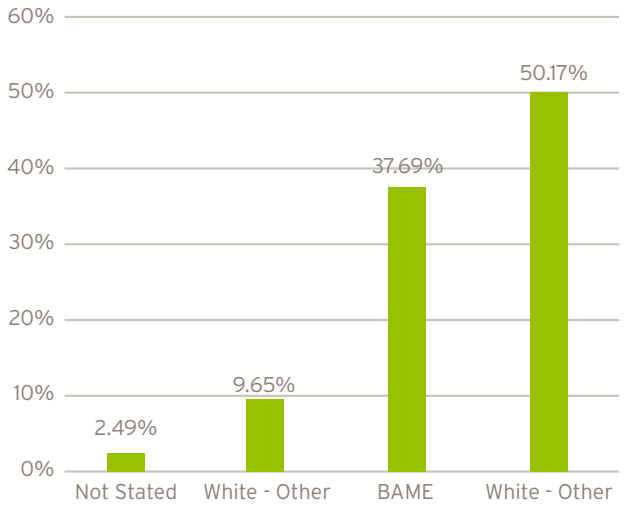
Over 40% of the nursing and midwifery workforce declare themselves as 'other than white' which is reflective of the local community.

Nursing & midwifery ethnicity



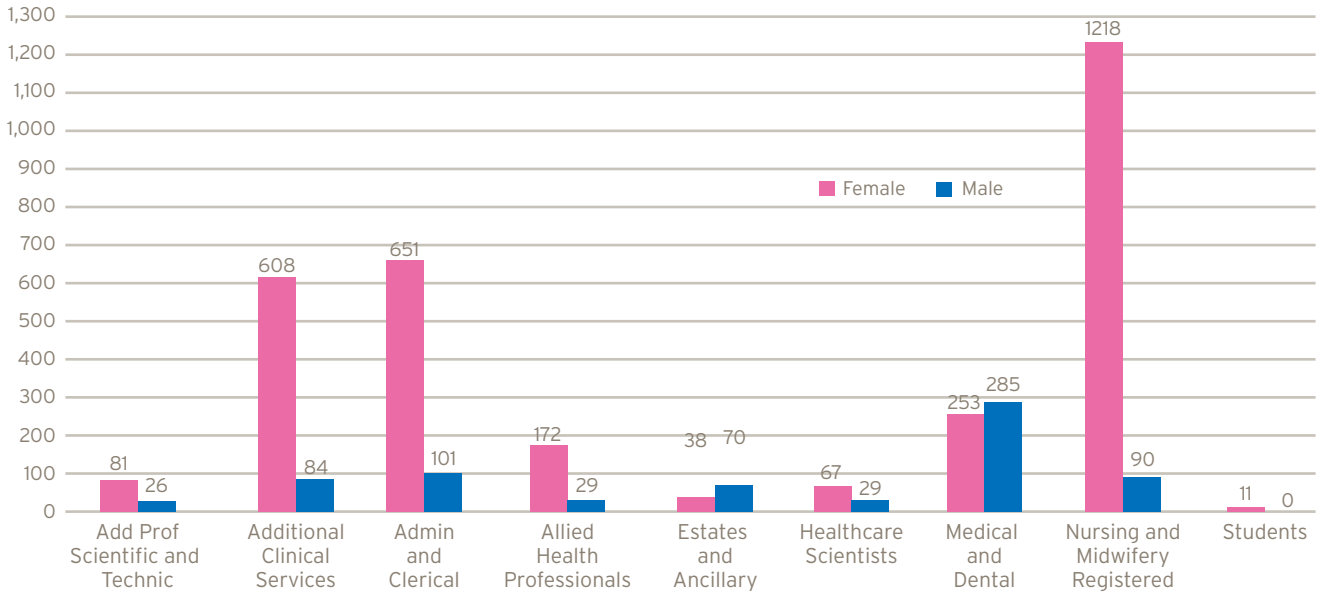
There has been a slight increase in the number of people who have declared their ethnicity since 2014 – 2015. This reflects the fact that people are generally more prepared to declare both ethnicity and age.

Workforce by ethnicity



The gender profile remains broadly similar to 2014 – 2015 with the majority of staff being female with the exception of Estates and Facilities and Medical and Dental staff.

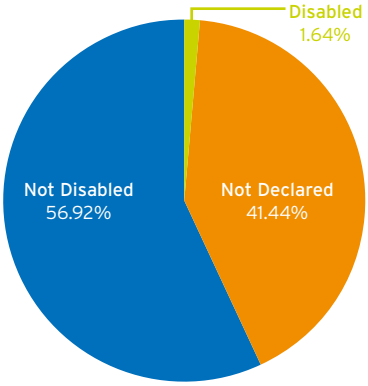
Gender by stafff group



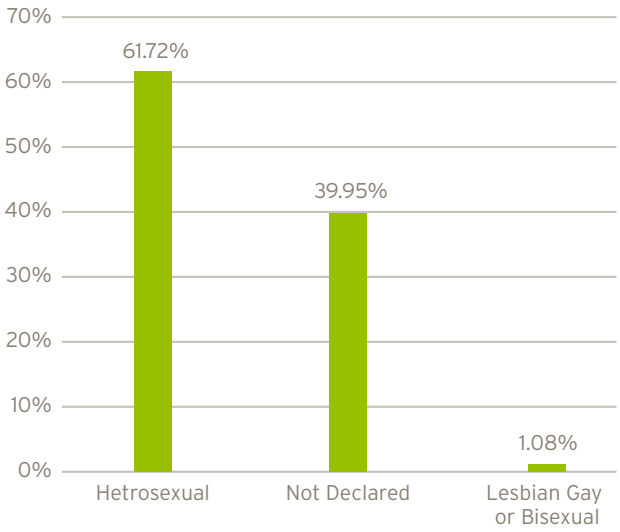
An additional 9% of staff have declared their status as not disabled since 2014 – 2015. The number of staff with a disability has remained broadly the same.

There has been an increase in the number of staff who have felt able to declare their sexual orientation. However, we are still not able to identify the full profile of staff due to non-disclosure.

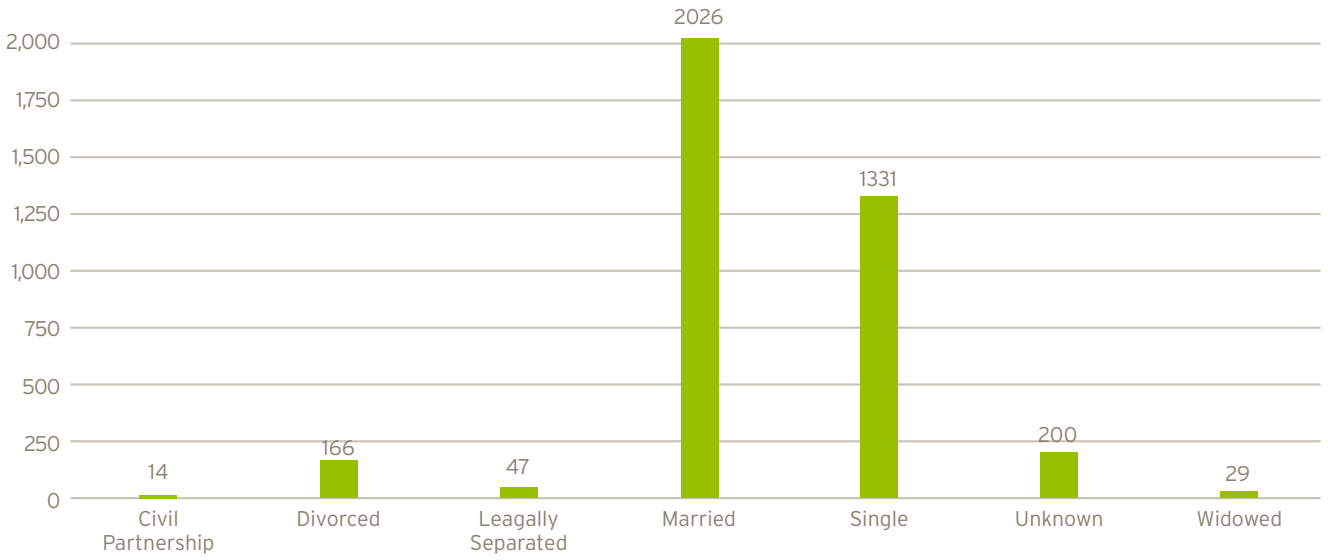
Disability



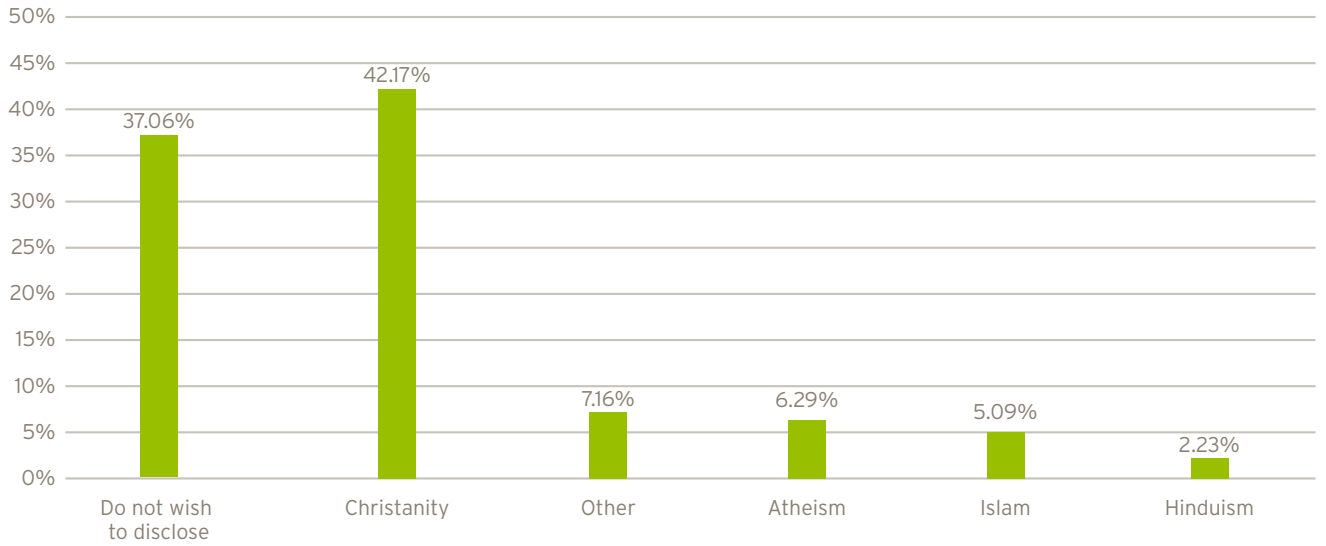
Workforce by Sexual Orientation



Workforce by Marital Status



Workforce by religion or belief



There has been a slight increase in the number of staff who are prepared to disclose their religion. Nevertheless, as a result of the continuing low disclosure levels, the figures are unlikely to be an accurate reflection of the workforce.
As at 31st March 2016 we had 133 employees on Maternity Leave. This equates to 3.48% of our workforce (4.29% of our female workforce).

Leavers from 1st April 2015 to 31st March 2016.

As a result of the outsourcing of catering and cleaning services, a significant number of staff have been transferred to the external contractor

Division	Total
Corporate	313
Diagnostics, Therapeutics and Outpatients	98
Medicine	238
Surgery	214
Women & Children's	126
Grand Total	**989**

Top Ten Leaving Reasons	Percentage of all Leavers
Employee Transfer - TUPE	22.65%
Voluntary Resignation - Other/Not Known	21.74%
End of Fixed Term Contract	19.41%
Voluntary Resignation - Relocation	9.10%

Top Ten Leaving Reasons	Percentage of all Leavers
Voluntary Resignation - Work Life Balance	5.86%
Voluntary Resignation - Promotion	4.95%
Retirement Age	4.85%
Voluntary Resignation - Child Dependants	1.72%
Voluntary Resignation - To undertake further education or training	1.52%
Voluntary Resignation - Better Reward Package	1.31%

Gender Pay Gap

There are more female than male staff represented across middle to senior grades. However, the proportion is more evenly spread between male and female staff at Band 8b and above.

AFC Band	Female	Male	Total	% of females
Band 7	328	45	373	87.94%
Band 8a	70	13	83	84.34%
Band 8b	27	11	38	71.05%
Band 8c	11	9	20	55.00%
Band 8d	8	2	10	80.00%
Band 9	3	3	6	50.00%
Grand Total	**447**	**83**	**530**	**84.34%**

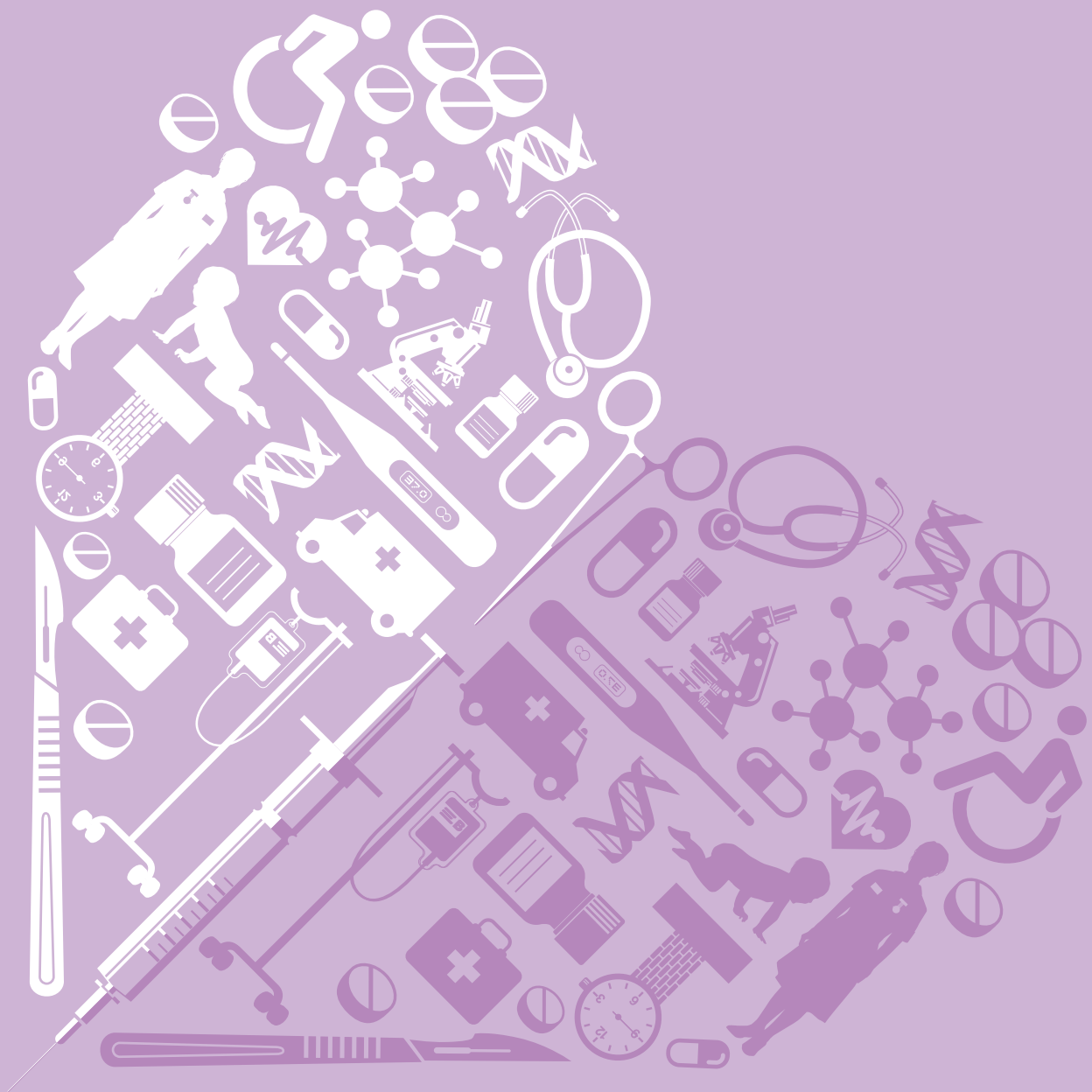
Working with Our Partners

The Trust contributes to nationally recognised and statutory partnerships through:

- Cross system networks to support high quality care and Choosing Health priorities such as cardiac network, diabetes network, mental health partnership arrangements and prevention of teenage pregnancy in maternity services.
- Local strategic partnerships such as System Resilience Groups and Bedfordshire and Luton Local Resilience Forum.
- Local Safeguarding Children's Boards (LSCB) – Luton LSCB and Bedfordshire LSCB.
- Local Safeguarding Vulnerable Adult Boards for Luton and Bedfordshire.
- East of England meetings and events.
- Regular CEO meetings with Clinical Commissioning Groups (CCG) Chief Officers, Directors of Social Care and the Chief Officer of the Local Area Team.
- Better Care Boards with Local Authority and CCGs.

Governance Report

Board of Directors	70
Committees of the Board of Directors	78
Council of Governors	82
Foundation Trust Membership	86



Board of Directors

The affairs of the Foundation Trust are conducted by the Board of Directors in accordance with the NHS Constitution and the Foundation Trust's Authorisation.

The Board manages the business of the hospital and is the legally responsible body for making decisions relating to the strategic direction, performance and overall running of the Foundation Trust. The Board has in place a schedule of decisions reserved for the Board and a delegation of powers document, setting out nominated officers to undertake functions for which the Chief Executive retains accountability to the Board.

The Board delegates its duties for the day to day operational activities of the hospital to the Executive Board which includes finance, activity, performance, safety, clinical quality and patient care. The Board comprises seven executive and seven non-executive directors and meetings are in a public setting every two months. In addition the Non-Executive and Executive Directors meet bi-monthly in a seminar session and attend monthly Council of Governors meetings or seminars.

As far as the Directors are aware there is no relevant audit information of which the auditors are unaware and the Directors have taken all the necessary steps to make themselves aware of any relevant audit information and to establish that the auditors are aware of that information.

Independent Professional Advice

The Board has access to independent professional advice, where it is judged that it is necessary to discharge their responsibilities as Directors.

The Role of the Chairman of the NHS Foundation Trust

The Chairman is pivotal in creating the conditions for cohesion between Board members and the executive roles of the directors. Specifically it is the responsibility of the Chair to ensure the effectiveness of the Board of Directors and to:

- Run the Board, taking account of the issues and concerns of Board members, be forward looking, and concentrate on strategic matters.
- Ensure that members of the Board receive accurate, timely and clear information to enable them to take sound decisions, monitor effectively and provide advice to promote the success of the Trust.
- Preside over formal meetings of the Council of Governors, and ensure effective communication between Governors and the Board of Directors and with staff, patients, members and the public.
- Arrange regular evaluation of the performance of the Board of Directors, its committees and individual Directors.

The Role of Non-Executive Directors (NEDs)

Our NEDs work alongside the Chairman and Executive Directors as equal members of the Board of Directors. The distinct roles of a Non-Executive Director are to:

- Bring independence, external skills and perspectives, and challenge to strategy development and Trust performance.
- Hold the Executive to account for the delivery of strategy; offer purposeful, constructive scrutiny and challenge; and chair or participate as member of key committees that support accountability.
- Actively support and promote a positive culture for the organisation and reflect this in their own behaviour; provide a safe point of access to the Board for whistle-blowers.
- Satisfy themselves of the integrity of financial and quality intelligence and that the system of risk management and governance are robust and implemented.
- Ensure the Board acts in best interests of the public; a Senior Independent Director (SID) is available to members and governors if there are unresolved concerns.
- NEDs including the Chair appoint the Chief Executive.
- As members of the Remuneration and Nomination Committee, determine appropriate levels of remuneration for Executive Directors; support the Chair in appointing and, where necessary removing executive directors, and in succession planning.
- Meet annually with the Chair to review the Chair's performance. The Senior Independent Director takes soundings from Governors.
- Consult with the Council of Governors to understand the views of governors and members and accounts to the Council of Governors in terms of the Statutory and NHS Foundation Trust Code of Governance requirements.

Information regarding the appointment and removal of Non-Executive Directors can be found in the Council of Governors section.

Remuneration and Interests

The remuneration of individual Directors can be found in note 4.5 to the accounts.

Board of Directors 2015/16

Name	Post Held	Year Appointed	Term of Appointment	Status
Appointment	Status			
Mrs Pauline Philip	Chief Executive	2010	Permanent	
Mr Andrew Harwood	Director of Finance	2000	Permanent	
Mr David Carter	Managing Director	2011	Permanent	
Mrs Pat Reid	Chief Nurse	2012	Permanent	
Dr Mark Patten	Medical Director	2012*	Permanent	To September 2015
Dr Danielle Freedman	Chief Medical Advisor	2015*	Interim voting	
Ms Angela Doak	Director of Human Resources	2010	Permanent	
Mr Mark England	Director of Re-Engineering and Informatics	2014	Permanent	
Mr Simon Linnett	Chairman	2014	3 Yr Fixed Term	To September 2017
Mr Clifford Bygrave	Non-Executive Director	2006+	Annual	Left July 2015
Ms Alison Clarke	Non-Executive Director	2006+	Annual	To July 2016
Mr John Garner	Non-Executive Director	2012***	3 Yr Fixed Term	To May 2018
Dr Vimal Tiwari	Non-Executive Director	2012***	3 Yr Fixed Term	To May 2018
Mr Mark Versallion	Non-Executive Director	2014	3 Yr Fixed Term	To October 2017
Mr David Hendry	Non-Executive Director	2014	3 Yr Fixed Term	To October 2017
Mrs Jill Robinson	Non-Executive Director	2014	3 Yr Fixed Term	To October 2017

* Appointed as Medical Director (at the L&D since 1998)
** Appointed as Chief Medical Advisor (at the L&D since 1987)
*** Term renewed 2016
\+ Reflects appointment to Board of Foundation Trust

A declaration of interest register is available for viewing in the Trust Offices

Compliance with the NHS Foundation Trust Code of Governance

It is considered that the Luton and Dunstable University Hospital NHS Foundation Trust complies with the main and supporting principles of the Code of Governance. This includes the issues of whether or not all of the Non-Executive Directors are independent in accordance with code provision B.1.1. The Board has determined that all of the NEDs are independent in character and judgement.

In relation to the more detailed provisions of the Code of Governance, the Trust are compliant with the provision with the exception of section B.1.2 in that the Board does not have half the Board of Directors as Non-Executive Directors excluding the Chair. In our Constitution the Chair votes as a Non-Executive and has a casting vote.

Independent Evaluation of Board Performance both Collectively and Individually

The Board continuously analyses its performance, duties and role on an ongoing basis and employs a Board Secretary to observe the board activity and report

findings into the Board of Directors. The Board analyses its own performance at the end of each Board meeting and also requests feedback from Governor Observers at each meeting that is subsequently reported to the Council of Governors.

HM Treasury

The FT has complied with cost allocation and charging guidance issued by HM Treasury.

Board Evaluation

During 2013 an assessment of the Trust's governance arrangements was undertaken through the Institute of Directors. The Institute of Directors has no connection to the Trust.

The effective functioning of the governance arrangements of the board is key to the success of the organisation. Board evaluation is extremely valuable in contributing to board effectiveness which has been recognised through various governance codes over the years particularly Monitor's Code of Governance that suggests an external Board Evaluation every three years. Periodic and rigorous board evaluation process represents best-practice and should be considered as part of any governance review.

The review found that the Board and Governance structures were robust and there was a good spread of knowledge across the Board members. The feedback did include the following recommendations that were supported by the Board and continue to be progressed or implemented:

- Development of a succession planning framework – on-going review of the Executive and Non-Executive roles through the relevant Remuneration and Nomination Committees.
- Further involvement of stakeholders in the development of our future strategy – the Trust has been central to the strategy development across the Trust catchment area during 2015/16.
- Development of a communication programme for staff about the annual plan – the Trust implemented a 'Good – Better – Best' engagement programme during 2015/16 that supported the communication of key areas of development including any plans.
- On-going involvement of the Divisional Directors in the Board Seminars – all Directors are involved in the Board Seminars including Clinical Chairs, Divisional Directors and other Directors.

The Board of Directors continued to hold a number of seminars throughout the year and to assess the strategic direction of the Trust.

During 2015, the Trust implemented the plans to restructure the Medicine Division to increase the clinical accountability at specialty level. An independent review from PricewaterhouseCoopers (PwC - internal audit) was requested during 2015/16. Plans were also developed for this implementation programme for the surgical division.

All Trusts must be subject to an external Board review following the Monitor Well Led Framework every three years and we are planning a review during 2016/2017.

Trust Directors: Expertise and Experience

Executive Directors

Mrs Pauline Philip
Chief Executive

Pauline joined the L&D as Chief Executive on 1st July 2010. With a strong clinical background, together with a number of highly successful Chief Executive positions, she brings a unique combination of skills and experience to the Trust.

Her vision is to create an organisation that puts patients first every time and that constantly strives to ensure that every patient receives safe care and the best clinical outcomes available in the NHS.

Pauline has an enviable track record in healthcare having spent over eight years in key Chief Executive positions at NHS Trusts in London, followed by her appointment as Director of Mental Health for the London Region of the Department of Health.

In 2002, she was seconded to the World Health Organisation (WHO) to establish a department dedicated to global patient safety. Pauline's appointment at the L&D follows her success at WHO and her proven expertise in leading and driving positive change through complex organisations.

In December 2015, Pauline was appointed to the position of National Director for Urgent and Emergency Care on a part-time secondment from the Trust. David Carter, Managing Director acts up to cover her duties when she is not in the Trust and NHS England have provided financial compensation to provide for other necessary support.

(Membership of Committees – CF, FIP, COSQ, HRD)

Mr David Carter
Managing Director

David Carter has twenty years' experience as a Board Director for various NHS organisations including mental health, community and primary care trusts and in the acute sector at Barnet and Chase Farm Hospitals NHS Trust. David's background is in finance and prior to joining the NHS he spent seven years at KPMG in London working in audit and consultancy where he qualified as an accountant.

David has overall responsibility for operational and estates, performance and contracting.

David acts as Deputy CEO in Pauline's absence.

(Membership of Committees – CF, FIP, COSQ, HRD)

Mr Andrew Harwood
Director of Finance

Andrew has been the Director of Finance since February 2000, with overall responsibility for the Trust's finances. He is responsible for procurement and contractual arrangements including with our commissioners.

Andrew's robust approach to financial management has helped to ensure that the L&D has successfully balanced its books in each of the last 15 years. With over 20 year's finance experience in the NHS, gained in health authorities and individual Trusts, he co-ordinated the Trust's financial strategy for our application for NHS Foundation Trust.

(Membership of Committees – CF, FIP, HRD)

Dr Mark Patten
Medical Director (to September 2015)

Mark has worked at the L&D since 1998 as a Consultant in Critical Care & Anaesthetics and has held numerous managerial positions, including being a Clinical Director from 2008–2010, Associate Medical Director from 2010–2011 and Divisional Director of Surgery since April 2011. During the last 12 years Mark has taken a particular interest in patient safety and has found time to undertake a number of tours of duty as a Royal Navy Reservist.

(Membership of Committees – CF, FIP COSQ, HRD)

Dr Danielle Freedman
Chief Medical Advisor* (from September 2015)

Danielle is a Consultant Chemical Pathologist and Associate Physician in Clinical Endocrinology and Director of Pathology. In addition, she was the hospital Medical Director from October 2005 until December 2010.

She trained in medicine at the Royal Free Hospital School of Medicine, London University and then went on for further training in Clinical Biochemistry and Endocrinology both at the Royal Free Hospital and the Middlesex Hospital, London University.

Nationally, in the UK, she was an elected Vice President of Royal College of Pathologists (2008 – 2011) and sat on RCPath Executive and Council (2005 – 11). She was Chair of the RCPath Speciality Advisory Committee for Clinical Biochemistry (2005 – 11). She is a Member of the UK NEQAS Clinical Chemistry Advisory Group for Interpretative Comments (2010 -) and also Member of ACB Council (2011-2015). She is now the Chair of Lab Tests Online Board UK (2012).

Her main interests include clinical endocrinology, point of care testing and, importantly, the role of the laboratory/ clinician interface with regard to patient safety and patient outcome. She has over 100 publications in peer review journals including Lancet, New England Journal of Medicine, JAMA and Annals of Clinical Biochemistry in her areas of interest.

She is a frequently invited speaker both nationally and internationally on the above topics. She won the 'Outstanding Speaker' award in 2009 from the American Association of Clinical Chemistry (AACC) and was a Member of the AACC Annual Meeting Organising Committee (AMOC) for 2011(Atlanta) and also Member of AMOC for 2014.(Chicago). She was also on the Scientific Committee for EUROLAB FOCUS 2014 (Liverpool, UK).

*Acting Medical Directors David Kirby, James Ramsay, Robin White & Nisha Nathwani

(Membership of Committees – CF, COSQ, HRD)

Ms Angela Doak
Director of Human Resources

In November 2010 Angela took up post as the Director of Human Resources in an acting capacity, after initially joining the Trust in July 2010 as Associate Director of Human Resources.

Angela has over 20 year's experience in human resources and organisational development in acute NHS trusts. Just prior to joining the Trust Angela held the post of Director of HR in a Foundation Trust. She has a strong track record in providing high quality HR services and her particular areas of interest and expertise include dealing

with major organisational change, complex employee relations cases and also employment matters concerning medical staff.

(Membership of Committees – COSQ, CF, FIP, HRD)

Mrs Patricia Reid
Chief Nurse

Pat was previously the Deputy Chief Nurse at Cambridge University Hospitals NHS Foundation Trust. Pat trained as a nurse at University College Hospital London and had numerous senior nurse posts before moving into publishing as Editor of the Nursing Times. She was also the very first nurse on the board of the BMJ.

Pat has a broad experience in the NHS having also undertaken General Management and service redesign roles.

(Membership of Committees – COSQ, CF, HRD)

Mr Mark England
Director of Re-Engineering and Informatics

Mark joined the Trust in 2008 from the London Borough of Croydon where he had been a Chief Information Officer for Children's Services for four years. There he delivered high-quality, commercially competitive technology services to almost 150 schools, while leading multiple high profile eGovernment projects. Many of these were Pan-London, including leading the technical delivery of the award winning shared eAdmission portal used by 100,000s of parents each year. By enabling electronic channels of payment Croydon was also the first authority to take cash transactions out of all schools, releasing considerable financial and quality benefits. His first exposure to the NHS was working to develop an early Children's Index with local NHS providers in South London.

Prior to that he spent five years working as a Project Manager on the development, and global implementation, of a web-based multilingual Enterprise Resource Planning (ERP) system. This was focused on supporting the delivery of Reproductive Health services in the developing world, and was implemented in 140 countries in four languages. Qualified as a software engineer, specialising in multi-lingual application design, he worked across multiple sectors on commercial internet based applications for many years.

(Membership of Committees – CF, FIP, HRD)

Non-Executive Directors

Mr Simon Linnett
Chairman

Simon Linnett is an Executive Vice Chairman at Rothschild in London. He has devoted a large part of his professional life to working within the public/private interface both nationally and internationally and is responsible for the bank's relationship with the UK government. He has had a long association with the health dialogue including the health reform process and the health debate generally and has engaged with various government bodies and other health institutions on this subject. Simon has previously headed Rothschild's global transport group and remains closely involved with its initiatives. He has a strong personal interest in the "green" debate, seeking to influence discussion on reducing emissions and chairing Rothschild's Environment Committee. Simon graduated from Oxford in Mathematics in 1975 and joined N. M. Rothschild & Sons Ltd where he has been ever since. Simon's external roles include: on the Council and Treasurer of Queen Mary University London; Trustee of the Science Museum Group; Chairman of the Independent Transport Commission; and Trustee of Exbury Garden Trust (a Rothschild family garden). He is a Trustee of NESTA.

(Membership of Committees – CF, RNC, FIP, HRD)

Mr Clifford Bygrave
Vice Chairman and Senior Independent Director
To July 2015

Clifford Bygrave is a Fellow of the Institute of Chartered Accountants in England and Wales, a Chartered Tax Adviser and a Member of the Society of Trust and Estate Practitioners. He is the Senior Independent Director and Vice Chairman of the Board. Clifford has been a Non-Executive Director at the L&D since 2001. He also served as Non-Executive Director of Bedfordshire Health Authority until its merger with the East of England Strategic Health Authority and was Chairman of the L&D's Audit and Risk Committee.

Following his retirement as a partner at Ernst & Young, Clifford is now the National Finance Director of the Boys' Brigade. He has served on the Council of the Institute of Chartered Accountants in England and Wales for 23 years. He also represented the UK Accounting bodies on the International Federation of Accountants Ethics Committee for five years. In addition he represented his Institute in Brussels for a number of years. In view of his seniority on the L&D Board and his extensive governance experience Clifford was appointed as L&D's Senior

Independent Director with effect from July 2007.

Cliff has remained Chair of the Charitable Funds Committee.

(Membership of Committees – AC, CF, FIP)

Ms Alison Clarke
Non Executive Director
Vice Chair and Senior Independent Director
(From July 2015)

Prior to being appointed as Non-Executive Director in 2002 Alison held Chief Officer and Assistant Director posts in several London local authorities. Her special areas of interest and expertise are performance management, quality management and human resources. She was awarded an MBA in 2000. In view of her experience in July 2015 the L&D Board appointed Alison as L&D's Senior Independent Director and Vice Chair.

(Membership of Committees – COSQ, CF, RNC, AC)

Mr John Garner OBE
Non Executive Director

John began life in HM Forces serving overseas and then coming out to become a Police Officer, Teacher and Education Officer HMP Preston. From this point he entered local government to become a Chief Officer in a number of authorities in the North Department Community Services (Environmental Health, Leisure and Housing).

After a career in local government he became the Chief Executive of the National Union of Students and progressed from there to become Controller for Sport and Entertainment at Wembley Stadium Ltd.

John has been the Chair of integrated governance, Deputy Chair of the Audit Committee, NED with South Beds PCT and Chair of Beds Shared Services Board. He has also been the Chair of Beds Children's Safeguarding Board. He was NED and Chair of Audit, Chair Information Governance, Chair Risk Committee Milton Keynes Community Health Services. In addition to this John has been a NED and Audit Committee member for the Football Licensing Authority DCMS and Chair of Audit for the Government Office NW and Member Dept Communities and local Government Dept Audit and Risk Management Committee.
John was also awarded an OBE for his services to children with special needs.

(Membership of Committees – AC, CF, RNC, FIP, HRD)

Dr Vimal Tiwari
Non Executive Director

Dr Vimal Tiwari was educated at Aberdeen University Medical School and St Mary's Hospital London, and also has a Master's Degree in Medical Education from the University of Bedfordshire. She has worked as a GP in Hertfordshire for over 30 years and as a Named Safeguarding GP for 8 years, with parallel careers over the years in Mental Health, Community Paediatrics, Medical Education and more recently Clinical Commissioning. She maintains a strong interest in Child Health, while being committed to securing the best quality compassionate, modern and comprehensive health care for all ages.

She was elected to Fellowship of the Royal College of General Practitioners in May 2016 for services to the College as Clinical Lead in Child Health and Child Safeguarding and contributions to educational resources including editing the 2014 edition of the RCGP/NSPCC Safeguarding Children Toolkit

(Membership of Committees – AC, CF, RNC, COSQ)

Mr Mark Versallion
Non Executive Director

Mark was appointed to the Board in December 2013. He has twenty years experience in the commercial sector, with companies such as BAE Systems plc and Capgemini plc, as well as having worked for U.S. Senators and U.K. Government Ministers in the 1990s. He was a non-executive director at NW London NHS Hospitals Trust from 2008-13.

A naval officer in the reserves for seventeen years he was a Councillor at the London Borough of Harrow for nine years. He has been a Councillor at Central Bedfordshire Council since 2011, in charge of children's services and schools.

(Membership of Committees – AC, FIP, CF, RNC)

Mr David Hendry
Non Executive Director

David was born in Luton and qualified as a Chartered Accountant with Whittaker &Co in Castle Street before gaining further professional experience with KPMG.

Following eight years in the profession he moved into the retail sector, firstly with BHS plc, where he went through

a series of promotions ultimately heading the Finance Directorate and contributing to the company's significant turnaround. He was then recruited by TK Maxx as the US retailer's European Finance Director, helping them adapt and profitably grow the concept from four UK stores to 212 operating in three countries over the 11 years he was there.

Wanting to gain experience in the public sector, he then spent six years with Transport for London as Surface Transport Finance Director, the division which facilitates 80% of all journeys through the capital's streets and rivers, contributing to significant improvements in service and efficiency over this period.

In 2014 David decided to pursue a portfolio career, giving him more personal flexibility and opportunity to utilise his skills. He sees the Non-Executive role at L&D as a significant opportunity helping support the right to health and treatment for all, and to do so in an area that has been home to him throughout his life.

(Membership of Committees – AC, CF, HRD, COSQ, RNC, Attends FIP)

Mrs Jill Robinson
Non Executive Director

Jill has a background in Financial Services and qualified as a certified accountant with Prudential plc. Having gained extensive financial, management and project accounting experience Jill moved into operational roles to use her accountancy skills and progressed to become Operations Director of Prudential Europe and then Operations Transformation Director for Prudential UK. Jill moved to Equitable Life Assurance Society as Operations Director where she was responsible for delivering two regulated projects allowing release of reserves of £540m, restoring stability to the servicing through the elimination of backlogs and resolving complaints within two days. From there she moved to Mercer as Partner, Head of Customer Service Delivery. Jill was responsible for the development of a new operational model, resulting in cost reduction of 30% and improvement of service level standards to 98%. Jill is currently Outsourcing and Finance Director for Marine & General Mutual, setting strategy and effecting the sale of the company. Jill is passionate about enthusing teams to deliver improved services, at reduced cost, for the benefit of customers and considers it a privilege to be able to use her skills in the NHS for the benefit of patients and staff alike.

(Membership of Committees – AC, CF, FIP, RNC)

Key to committees:

COSQ – Clinical Outcomes, Safety and Quality Committee
CF – Charitable Funds Committee
RNC – Remuneration & Nomination Committee
AC – Audit and Risk Committee
FIP – Finance, Investment and Performance Committee
HRD – Hospital Re-Development Programme Board

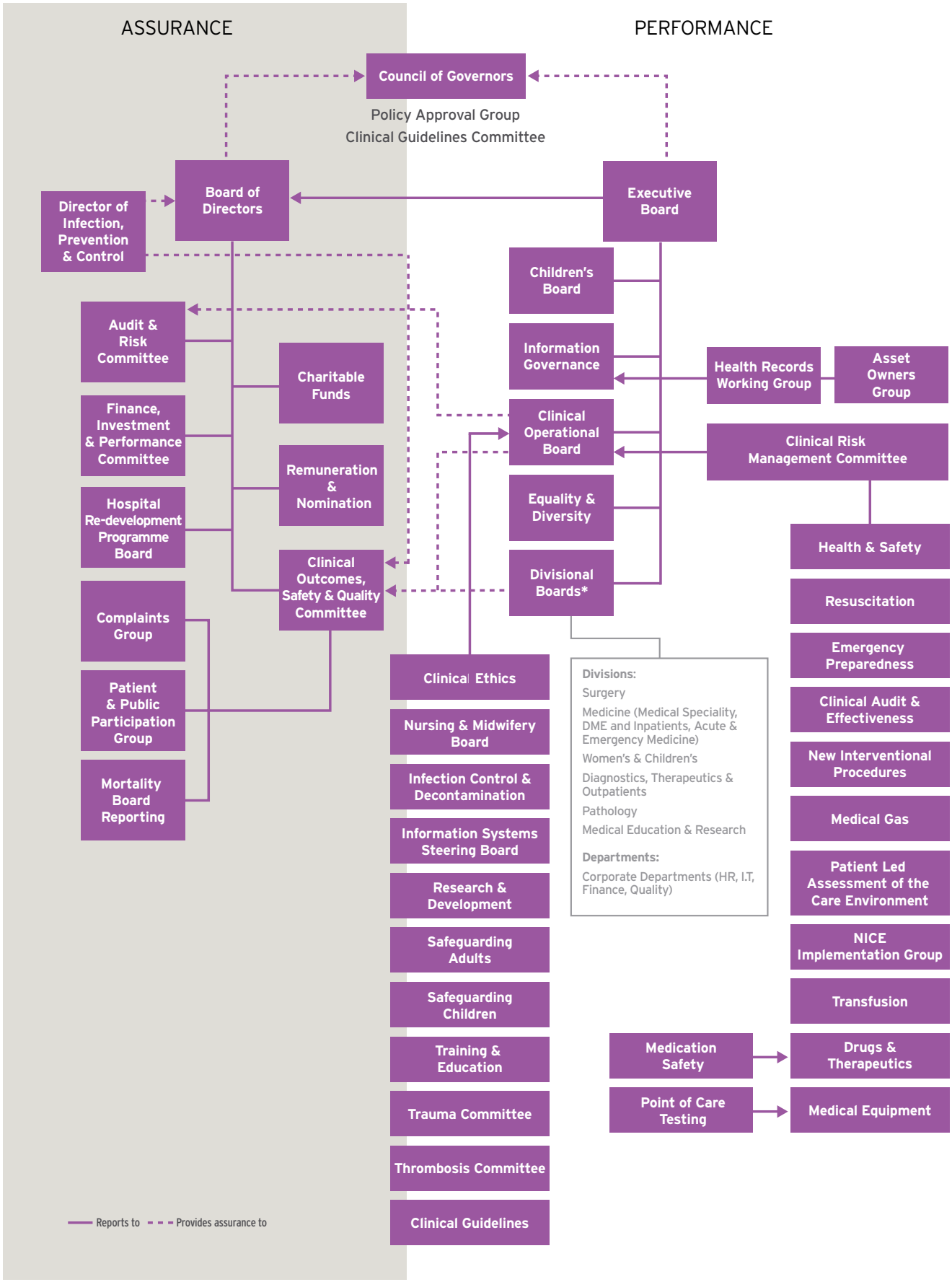
Record of committee membership and attendance

Total Meetings	Public Board Meetings	Private Board Meetings	Audit & Risk	Remuneration and Nomination	Charitable Funds	COSQ	HRD	FIP
Pauline Philip	5/5	9/10*			1/3*	7/11*	4/7*	10/11*
Simon Linnett	5/5	10/10		3/3	2/3		7/7	9/11
Andrew Harwood	5/5	10/10			3/3		6/7	11/11
David Carter	5/5	10/10			2/3	8/11	5/7	10/11
Pat Reid	5/5	9/10			0/3****	10/11	1/7****	
Mark Patten	1/2**	2/4			0/1	4/4	3/3	3/4
Angela Doak	3/5***	7/10***			3/3	10/11***		8/11***
Mark England	4/5	10/10			3/3		4/7	11/11
Medical Directors	3/3	6/6				6/7		
Clifford Bygrave to July 2015	2/2	3/3	1/1	1/1	1/1			3/4
Alison Clarke	5/5	10/10	4/4	3/3	2/3	10/11		
John Garner	5/5	10/10	4/4	3/3	3/3		4/7	11/11
Vimal Tiwari	5/5	9/10	3/4	3/3	2/3	11/11		
Mark Versallion	5/5	9/10	3/4+	3/3	2/3 +			8/11 +
David Hendry	5/5	10/10	4/4	3/3	3/3	9/11	7/7	7/7
Jill Robinson	5/5	10/10	3/4	3/3	2/3			10/11

* Denotes that David Carter deputised for Pauline Philip
** Denotes that Malcolm Griffiths deputised for Mark Patten
*** Denotes that J Rosenblatt deputised for Angela Doak
**** Operational matters have often meant that the Chief Nurses is required to oversee the safety of the organisation
\+ Unable to attend due to meetings being rescheduled

Committees of the Board of Directors

Luton and Dunstable Hospital Governance and committee structure



* Divisional Board meeting include standard agenda items of Risk Management, Risk Registers, Incidents, Complaints and claims and information related to each of the relevant sub-committees of the Clinical Operational Board

Audit and Risk Committee

The function of the Audit Committee has been to ensure an adequate and effective operation of the Trust's internal control system. The committee focuses on the establishment and maintenance of controls designed to give reasonable assurance that assets are safeguarded, waste and inefficiency avoided, reliable information produced and that value for money is continuously sought.

Key responsibilities delegated by the Board to the Audit and Risk Committee are to:

- Ensure the establishment and maintenance of an effective system of integrated governance, risk management and internal control across the whole of the Trust's activities (both clinical and non-clinical), that supports the achievement of the Trust's objectives.
- Monitor and review compliance with Standing Orders, Standing Financial Instructions and Scheme of Delegation.
- Review the annual financial statements and Annual Report for compliance with accounting standards and legal requirements before submission to the Board of Directors.
- Review the annual Counter Fraud programme and ensure the Trust is adequately resourced to meet the requirements of the Directorate of Counter Fraud;
- Ensure cost-effective external audit.
- Appoint, monitor and review Internal Audit service.
- Report to the Council of Governors on any matters that require immediate action and make recommendations on steps to be taken.

Membership of the Audit and Risk Committee:

The Audit Committee membership has been drawn from the Non-Executive Directors and was chaired by Mr Clifford Bygrave (Non Executive Director and Senior Independent Director (SID) until July 2015) and is now chaired by Mr David Hendry (NED).

Audit and Risk Committee Report

The Audit and Risk Committee reviewed financial and operating performance and compliance against national and regulatory standards. A comprehensive work plan is agreed each year which ensures oversight and monitoring of risks, mitigations and issues relating to the financial statements, internal controls and compliance with regulatory, statutory responsibilities and internal policies and procedures which in turn enables action to be escalated as appropriate, i.e. officer attendance to explain critical risk or failure to implement internal audit recommendations and escalation to the Board where appropriate. An annual report of the Committee's activities and how the Committee has fulfilled its role is reported by the Chair of the Audit & Risk Committee to the Board and the Council of Governors. The Committee has had close oversight throughout the year of the Board Assurance Framework and principal risks on efficiency planning and sustainability. In depth reviews of operational risks on the register include: Key Financial Controls, Waiting Times, Safeguarding Adults; Safeguarding Children; Cost Improvement Plans; e Rostering; Risk Management (bed pressures);Clinical Governance and Culture of Learning; and Divisional Governance. In addition significant follow up was conducted on Activity Recording and Information Technology and have further supported the Committee's understanding and review of the key issues facing the Trust. In relation to CQC compliance with care standards, the Committee reviews regular reports from the Clinical Outcome Safety and Quality Committee.

Internal Audit

The Audit and Risk Committee has been assured by the Head of Internal Audit Opinion on the Trust's internal control environment and positive approach to identifying, assessing and mitigation planning to risks. This was supported by in year and year end internal audit reviews of the and Corporate Risk Register subject to submission to the Audit and Risk Committee on the 18th May 2016.

External Audit

The Audit and Risk Committee engages regularly with the external auditor throughout the financial year, including holding private sessions with Non Executive Directors.

The Audit and Risk Committee considers the external audit plan, technical updates, any matters arising from the audit of the financial statements and the Quality Account and any recommendations raised by the external auditor.

The External Audit programme is scheduled to focus on key areas of risk and for 2015/16 the areas of audit risk were:

- Valuation of land and buildings
- Recognition of NHS and non-NHS Income
- Fraud risk from revenue recognition
- Fraud risk from management override of controls

The external audit opinion is reported within the ISA 260 and is summarised below.

KPMG have read the contents of the Annual Report (including the Accountability Report, Performance Report and AGS) and audited the relevant parts of the Remuneration Report. Based on the work performed KPMG:

- Did not identify any inconsistencies between the contents of the Accountability, Performance and Director's Reports and the financial statements;
- Did not identify any material inconsistencies between the knowledge acquired during our audit and the director's statements. The Board of Directors confirmed that it considers the annual report and accounts taken as a whole are fair, balanced and understandable and provides the information necessary for patients, regulators and other stakeholders to assess the Trust's performance, business model and strategy;
- The part of the Remuneration Report that is required to be audited were all found to be materially accurate; and
- The AGS is consistent with the financial statements and complies with relevant guidance subject to updates.

The appointment of the auditor was made in 2012 as a result of a competitive process under a procurement compliant framework. The appointment was extended in 2014 on the same terms. Each appointment is subject to Council of Governors agreement. Reports from External Audit are received and reviewed at each Audit and Risk Committee to assess the effectiveness of the external audit programme. External Audit confirmed they were able to complete the required testing against the controls in the fee agreed with the Trust.

Organisation going concern status has been specifically discussed with the External Auditors in relation to the financially challenging environment the Trust faces. Assurance on the accounts review of the "going concern" opinion is based on risk to service continuity and that the Trust is able to confirm service continuity and therefore going concern status over the medium term.

KPMG LLP have also provided tax advice on an ad hoc basis during 2015/16 totalling £22,000. Each assignment was subject to an individual engagement letter and undertaken by a separate division within the organisation thereby avoiding any objectivity or independence issues.

Remuneration and Nominations Committee

This Committee reports to the Board of Directors and acts as defined in the Standing Financial Instructions, Standing Orders and Code of Governance documents.

The Committee has delegated responsibility from the Trust Board for the appropriate remuneration for the Chief Executive, other Executive Directors employed by the Trust and other senior employees on locally agreed pay arrangements, including:

- All aspects of salary.
- Provisions for other benefits, including pensions and cars.
- Arrangements for termination of employment and other contractual terms;
- Review the composition of the Board of Directors and make recommendations as to the appropriate make-up of the Board.
- Make recommendations to the Nomination Committee of the Council of Governors in respect of Non-Executive Director positions.

Membership of the Remuneration and Nominations Committee:

The Remunerations and Nominations Committee has been drawn from the Board members and is chaired by Mark Versallion (NED).

Charitable Funds Committee

The L&D is a Corporate Trustee. The Charitable Funds Committee on behalf of the Corporate Trustee agrees proper use of charitable funds and approves fundraising schemes.

Key responsibilities are to:

- Keep proper accounting records and prepare accounts in accordance with applicable law.
- Safeguard the assets of the charity.
- Take reasonable steps for the prevention and detection of any fraud and other irregularities.
- Determine operating procedures for the administration of charitable funds.
- Appoint investment advisors.
- Appoint independent auditors.

Membership of the Charitable Funds Committee:

The Charitable Funds Committee membership has been drawn from Board members. In September 2015, the Board of Directors agreed an independent chair of this committee and Mr Clifford Bygrave was appointed.

Clinical Outcome, Safety and Quality Committee

The Clinical Outcome, Safety and Quality Committee provide assurance to the Board of Directors that the Trust is compliant with legislation and guidance on clinical, patient safety and quality issues.

The Clinical Outcome, Safety and Quality Committee monitors the implementation of strategic priorities and the organisations performance in relation to clinical outcome and research and development. It ensures compliance with regulatory requirements and best practice within the patient safety and quality improvement agenda.

Membership of the Clinical Outcome, Safety and Quality Committee:

The Clinical Outcome, Safety and Quality Committee membership includes Board members, and is chaired by Alison Clarke (NED and SID).

Finance, Investment and Performance Committee

The purpose of the Finance, Investment and Performance Committee has been to lead the strategic direction of the Trust's finance work, approving capital bids and plans and monitoring performance.

Membership of the Finance, Investment and Performance Committee:

The Finance Investment and Performance Committee membership included Board members, senior managers and clinicians and is chaired by Mrs Jill Robinson (NED).

Hospital Re-Development Programme Board

The purpose of the Hospital Re-Development Programme Board has been to lead the progression of the Outline Business Case following approval of the Strategic Business Case at the Board of Directors on the 1 October 2014 progressing to the full business case and enabling works.

Membership of the Hospital Re-Development Programme Board:

The Hospital Re-Development Programme Board membership included Board members, senior managers and clinicians and is chaired by Mr Simon Linnett.

Council of Governors

The constitution defines how we will operate from a governance perspective and it is approved by the Board and the Council of Governors. The basic governance structure of all NHS Foundation Trusts includes:

1. The Membership;
2. The Council of Governors; and
3. The Board of Directors

In addition to this basic structure, Board and Council of Governor committees and working groups, comprising both Governors and Directors, are used as a practical way of dealing with specific issues.

The specific statutory powers and duties of the Council of Governors are:

- Appoint and, if appropriate remove the Chair.
- Appoint and, if appropriate remove the other Non-Executive Directors.
- Decide the remuneration and allowances and the other terms and conditions of office of the Chair and the other Non-Executive Directors.
- Approve the appointment of the Chief Executive.
- Appoint and, if appropriate remove the NHS Foundation Trust's auditor.
- Receive the NHS Foundation Trust's annual accounts, any report of the auditor on them and the annual report.
- Hold the Non-Executive Directors to account for the performance of the Board
- Approve significant transactions as defined in the Trust's Constitution.

In addition:

- In preparing the NHS Foundation Trust's forward plan, the Board of Directors must have regard to the views of the Council of Governors.

The Monitor Code of Governance determines that every NHS Foundation Trust will have a Board of Governors which is responsible for representing the interests of NHS Foundation Trust members and partner organisations in the local health economy in the governance of the NHS Foundation Trust. Governors must act in the best interests of the NHS Foundation Trust and should adhere to its values and code of conduct. The Board of Governors should hold the Non-Executive Directors to account for the performance of the Trust, including ensuring the Board of Directors acts so that the Foundation Trust does not breach the terms of its authorisation. Governors are responsible for regularly feeding back information about the NHS Foundation Trust, its vision and its performance to the constituencies and stakeholder organisations that either elected them or appointed them. The Code of Governance states that one of the independent Non-Executive Directors should be appointed by the Board of directors as the "Senior Independent Director", or SID, in consultation with the Board of Governors. The SID should act as a point of contact if governors have concerns which contact through normal channels has failed to resolve or for which such contact is inappropriate. Mr Clifford Bygrave was the appointed SID for the Trust and was succeeded by Mrs Alison Clarke on his retirement in July 2015.

The constitution provides that the Board of Directors appoint a vice chairman from one of our Non-Executive Directors. The vice chairman should deputise for the chair as and when appropriate. Mr Clifford Bygrave was the Vice Chairman of the Trust and was succeeded by Mrs Alison Clarke on his retirement in July 2015.

It remains the responsibility of the Board of Directors to design and then implement agreed priorities, objectives and the overall strategy of the NHS Foundation Trust.

The Council of Governors was chaired by Mr Simon Linnett. Council of Governor meetings are held at least three times in each financial year and are open to the public and representatives of the press. Since September 2009 these meetings have been held every two months. In February 2016, the Council of Governors agreed to meet formally quarterly.

In October 2015 the Council of Governors re-elected Mr Roger Turner as Deputy Chair/Lead Governor of the Council of Governors for a term of two years. The Deputy Chairman or Lead Governor of the Council of Governors presides as chair of any meeting of the Council of Governors where the Chairman presiding at that meeting in terms of a conflict of interest (section 12.29 of the Constitution). The Lead Governor is also the nominated person that Monitor would contact in the event that it is not possible to go through the Chair or the Trust's Secretary.

The Council of Governors met seven times during 2015/16 and the attendance is recorded.

Register of Interests of the Council of Governors' Members

A declaration of interest register is available for viewing in the Trust Offices.

Elections

Our annual elections to the Council of Governors were held during May – August 2015. Electoral Reform Services (ERS) were our independent scrutiniser to oversee the elections, which were held in accordance with the election rules as stated in our constitution.

The following constituency seats were filled by uncontested candidates

- Staff: Professional and Technical

The following constituency seats were filled by election

- Public: Luton
- Public: Bedfordshire
- Public: Hertfordshire
- Staff: Nursing and Midwifery
- Staff: Administration, Clerical and Management
- Staff: Volunteers

Analysis of Annual Election Turnout:

Date of election	Constituencies involved	Number of members in Constituency	Number of seats contested	Number of Candidates	Election turnout %
August 2015	Public: Luton	6,372	4	9	15%
August 2015	Public: Bedfordshire	2,779	4	7	20%
August 2015	Public: Hertfordshire	1,552	2	5	15.8%
August 2015	Staff: Nursing and Midwifery (including HCAs)	2,164	2	4	15.4%
August 2015	Staff: Administration, Clerical and Management	768	1	2	25.1%
August 2015	Staff: Volunteers	141	1	2	43.3%

Governors in post – April 2014 to March 2015

Constituency	Name	Selection process	Changes in year	Term of office	Attendance of COG meetings
Appointed Governors					
Luton CCG	Carole Hill	Appointed to Apr 2016		3 years	5/6
Bedfordshire CCG	Vacant				
Hertfordshire CCG	Vacant				
Central Bedfordshire Council	Cllr Norman Costin	Appointed to 2018	Resigned	3 years	1/5
	Cllr Maurice Jones	Appointed to 2019	Start of 1st term		0/1
Luton Borough Council	Cllr Mahmood Hussain	Appointed to 2016		3 years	0/1
	Cllr Ayub Hussain	Appointed to 2018	Start of 1st term		1/3
University College London	Prof Brian Davidson	Appointed to 2016		3 years	1/6
Chamber of Commerce	Cheryl Smart OBE	Appointed to 2015		3 years	0/3
University of Bedfordshire	Vacant				
Public Governors					
Hertfordshire	Mr Donald Atkinson	Elected to 2018	Start of 1st term	3 years	3/3
	Mr John Harris	Elected to 2017		3 years	4/6
Public Governors					
	Ms Helen Lucas	Elected to 2018	Start of 1st term	3 years	1/3
	Mr Malcolm Rainbow	Elected to 2015	Term Ended	3 years	2/3

Constituency	Name	Selection process	Changes in year	Term of office	Attendance of COG meetings
	Mr Guy Thomas	Elected to 2015	Term Ended	3 years	1/3
Bedfordshire	Mrs Sandra Bowden	Elected to Sept 2017		3 years	6/6
	Ms Janet Curt	Elected to 2015	Term ended	3 years	2/3
	Miss Dorothy Ferguson	Elected to 2015	Start of 2nd term	3 years	6/6
	Ms Jennifer Galluci	Elected to 2018	Start of 1st term	3 years	2/3
	Mr Ray Gunning	Elected to 2015	Start of 3rd term	3 years	6/6
	Mr Bart Hanley	Elected to 2015	Term ended	3 years	0/3
	Mr Bob Shelley	Elected to 2016		3 years	6/6
	Mr Jim Thakoordin	Elected to 2018	Start of 1st term	3 years	3/3
	Mr Roger Turner	Elected to Sept 2017		3 years	6/6
Luton	Mr Keith Barter	Elected to 2016		3 years	5/6
	Ms Marie-France Capon	Elected to 2018	Start of 3rd term	3 years	4/6
	Mrs Susan Doherty	Elected to Sept 2017		3 years	4/6
	Mr Amer Hussain	Elected to 2016		3 years	1/6
	Mrs Judy Kingham	Elected to Sept 2017		3 years	6/6
	Mr Anthony Scroxton	Elected to 2016		3 years	6/6
	Mr Tariq Shah	Elected to 2016		3 years	2/6
	Mr Derek Brian Smith	Elected to 2018	Start of 2nd term	3 years	6/6
	Mrs Geraldine Tassell	Elected to Sept 2017		3 years	5/6
	Ms Shamim Ulzaman	Elected to 2016		3 years	4/6
	Mr Jack Wright	Elected to 2015	Term ended	3 years	3/3
	Mr John Young	Elected to 2015	Term ended	3 years	2/3
Staff Governors					
Admin, Clerical and Management	Mr Jim Machon	Elected to 2015	Start of 3rd term	3 years	5/6
	Mrs Ros Bailey	Elected to 2016		3 years	5/6
Nursing and Midwifery (including Health Care Assistants)	Mrs Belinda Chik	Elected to 2018	Start of 1st term	3 years	3/3
	Mrs Carmel Deveraux	Elected to 2017	Resigned	3 years	1/2
	Ms Jackie James	Elected to 2017	Resigned	3 years	0/0
	Mrs Pamela Vasallo-Todaro	Elected to 2017	Resigned	3 years	2/3
	Mrs Ann Williams	Elected to 2018	Start of 1st term	3 years	2/3
Volunteers	Mrs Pam Brown	Elected to 2015	Term ended	3 years	3/3
	Mrs Janet Graham	Elected to 2018	Start of 1st term	3 years	3/3
Medical and Dental	Dr Ritwik Banerjee	Elected to 2017		3 years	5/6
Ancillary and Maintenance	Mr Gerald Tomlinson	Elected to 2016		3 years	5/6
Professional and Technical	Ms Cathy O'Mahony	Elected to 2018	Start of 1st term		3/3
	Ms Barbara Turner	Elected to 2015	Term ended		1/3

Anyone wishing to contact Governors can write to the Governors' email address governors@ldh.nhs.uk or to the Board Secretary. The Members' Newsletter can be found on the L&D's website.

Council of Governors Sub Committees

There are three sub-committees of the Council of Governors

Remuneration and Nomination Committee
The Remuneration and Nomination Committee assists the Council of Governors in carrying out the following of its functions:

- To appoint and if appropriate remove the Chair.
- To appoint and, if appropriate remove the other Non-Executive directors.
- To appoint and, if appropriate remove the Vice-Chairman of the Board of Directors.
- To decide the remuneration and allowances and the other terms and conditions of office, of the Chair and the other Non-Executive Directors.
- To approve the appointment of the Chief Executive.
- To agree the outcome of the annual appraisals of the Non-Executive Directors by the Chair.
- To agree the outcome of the annual appraisal of the Chair by the Senior Independent Director.

During 2015/16 the committee met twice and has completed the following activities:

- Approved the remuneration and allowances for the Non-Executive Directors.
- Agreed the outcomes of the Non-Executive Directors appraisals.
- Completed the process to be able to recommend to the Council of Governors the extension of three Non-Executive Directors.

Membership and Communication Committee
The Membership and Communications Committee assists the Council of Governors in carrying out the following of its functions:

- To implement the Trust Membership Strategy.
- To be a contact for the Trust to encourage membership.
- To represent the Council of Governors and visit locations around the Trusts' constituencies to encourage membership.
- To support the publication of the Ambassador newsletter to members.
- To support the Annual Member's meeting.
- To ensure the Trust's Membership Strategy is reviewed yearly and remains fit for purpose.

During 2015/16 the committee met six times and has completed the following activities:

- Issued two Ambassador newsletters.
- Reviewed the Membership Strategy.
- Supported the two Medical Lectures on End of Life Care and Sepsis.
- Supported the Annual Member's Meeting.
- Visited locations across the catchment to increase membership.

Constitutional Working Group
The Constitutional Working Group assists the Council of Governors in carrying out the following of its functions:

- To ensure that the Constitution is up to date with new developments.
- To review the Constitution at least annually.
- Recommend amendments to the constitution to the Council of Governors;
- Liaise with Monitor and legal representatives when required.
- Report to the Annual Members Meeting to approve any Constitutional amendments.

- During 2015/16 the committee met once and agreed a number of improvements to the current constitution that were agreed by the Council of Governors in February 2015 and the Board of Directors in March 2015. None of the amendments affected the powers of the governors.

Foundation Trust Membership

The Trust's Governors and Members continue to play a vital role in our Constitution as a Foundation Trust. There are two broad categories of membership constituency namely public and staff (including volunteers). The public constituency is further divided into three:

i. Luton

ii. Bedfordshire

iii. Hertfordshire

The Trust currently has 16,508 members (12,073 public and 4435 staff). The FT public membership numbers increase around 3% each year and the Governors set a target of 600 new members annually. The Governors agree a Membership Strategy through the Council of Governors and follows six key objectives:

1) To increase the membership - The strategy outlines more focused work on recruiting members in Bedfordshire with an engagement approach to the Luton and Hertfordshire membership.

2) To ensure membership diversity - A review of the diversity of the membership identified that an increase the number of younger members was required. The Trust has made links with the Youth Parliament and Apprenticeship schemes.

3) To develop the membership database - In order to increase communication, the aim to maintain the number of recorded e-mails at 30%. The Trust has also initiated an email use group to expedite communications.

4) To provide learning and development opportunities to the membership - Two medical lectures were held for 2015/16 (End of Life Care and Sepsis/Infection Control) and two more are planned for 2016/17. Engagement events are also supported across the catchment area for the public and membership that provide opportunity to learn about the L&D services and speak to the medical team.

5) To communicate with the membership and encourage them to stand in elections - This has been part of the strategy for two years following an uncontested election of the Luton constituency. The Governors are key to ensuring that when members are recruited, they are also informed about being a Governor. At each of the L&D events, there is a stand to encourage members to stand for election and the Ambassador includes communication from present governors to provide clarity on the role and how they can be involved.

6) Effective use of resources - The Council of Governors Membership and Communication Sub-Committee reviews the budget on behalf of the Governors.

Strategy for 2016/17

The strategy will be reviewed in May 2016 by the Membership and Communication Sub-Committee to identify the plans for 2016/17. The main objectives will remain the same and plans to:

- Forecast an increase of the membership to 16,983 for period ending 31 March 2017.
- Further increase the membership and hold engagement events in Bedfordshire.
- Target key membership groups to discuss becoming Governors.
- Encourage members to vote for their preferred candidates in the elections.

In 2016/17 there are nine vacancies; 6 Public Governors (5 Luton, 1 Bedfordshire) and 3 Staff Governors (1 Admin, Clerical and Management, 1 Ancillary and Maintenance, 1 Nursing and Midwifery). During 2015/16, the Trust reviewed the voting profile of the membership and identified a diversity issue with the voting in the Luton Constituency. For the elections in 2016, an active programme to encourage voting will be put in place with our independent election provider.

Table 1: Membership size and movement:

Public constituency	2015/16 (Plan)	2015/16 (Actual)	2016/17 (Plan)
At year start (April 1)	11,641	11,641	12,051
New members	600	649	600
Members leaving	200	239	200
At year end (March 31)	12041	12,051	12,451
Staff constituency *			
At year start (April 1)	4504	4504	4450
New members	715	1014	1040
Members leaving	651	1068	958
At year end (March 31)	4568	4450	4532
Total Members	16609	**16501**	**16983**
Patient constituency			
Not applicable			

* The Staff Constituency in line with the Trust Constitution and includes volunteers and bank staff that are not part of the Trust headcount.

Table 2: Analysis of current membership:

Public Constituency	Number of members	Eligible membership+
Age (years):		
0-16	2	358,122
17-21	90	93,331
22+	8,776	1,193,552
Unknown	3,183	
Ethnicity:		
White	6,163	1,327,296
Mixed	86	40,567
Asian or Asian British	1,662	139,935
Black or Black British	500	54,924
Other	308	10,922
Unknown	3,332	
Socio-economic groupings: *		
AB	3,066	132,796
C1	3,490	154,585
C2	2,591	94,527
DE	2,846	94,885
Unknown	58	
Gender analysis		
Male	4,799	810,407
Female	7,218	834,599
Unknown	34	
Patient Constituency		
Not applicable		

Analysis excludes: 3,183 members with no date of birth, 34 with no stated gender, 3,332 with no stated ethnicity, and 58 with no stated socio-economic grouping.

Notes:

* Socio-economic data should be completed using profiling techniques (e.g. post codes) or other recognised methods. To the extent socio-economic data is not already collected from members, it is not anticipated that NHS foundation trusts will make a direct approach to members to collect this information.
+ The eligible membership includes the whole population of Bedfordshire and Hertfordshire which is larger than the hospital catchment area.

TOTAL - Eligible members:

AGE:	1,645,006
Ethnicity:	1,573,644 **
Socio-economic:	476,793 ***
Gender:	1,645,006

The figures for Ethnicity and Socio-economic do not add up to1,645,006.
The reasons provided by **Membership Engagement Services** are listed below:

The overall **Ethnicity figure for **Eligible members** is often lower than the other figures purely because it is based on a projection from the 2001 Census data so unable to provide a perfectly accurate representation.
***The overall **Socio-economic** figure for **Eligible members** is lower due to the fact that it only takes into account those between the ages of 16-64 leaving out those outside of that range.

Governor Training, Membership Recruitment and Engagement

The Trust continues to have in place a number of engagement activities to facilitate engagement between Governors, Members and the Public:

- Medical Lectures – the Trust held two lectures on key topics identified by the Governors – End of Life Care and Infection/Sepsis. Trust clinical staff presented to 150 or more members at each session.
- Engagement Events – around five engagement events were held across the Trust to support the Governors and Trust staff to engage with the public.
- Annual Members Meeting – the Trust had over 150 people at the Annual Members Meeting in September and it is considered an excellent event by those that attend.
- Membership recruitment – all Governors are involved with recruiting members. This ranges from visiting GP practices, attending events such as at the Chamber of Commerce and linking with local groups like the Women's Institute. A sub-committee of the Governors oversee this programme to ensure there is diversity of approach and this year we achieved our target 600 new members in 6 months of the year.
- Ambassador Magazine – The Trust issued two 20 page magazines – August 2015 and February 2016 and is the opportunity for the Governors to report back to the members about Trust progress, Governor involvement and how the Governors are holding the Non-Executive Directors to account.
- Being a Governor awareness sessions – The Trust offers awareness sessions for those interested in becoming a governor. These are held twice a year in April and October and also on a 1:1 basis as required.
- Governor training – Training is accessible to all Governors through NHS Providers GovernWell programmes. Additionally, during 2015, the Trust held a bespoke joint training programme with Milton Keynes Governors provided by GovernWell. This was an excellent opportunity for the L&D Governors to network and share ideas. The Trust plans to continue this programme for 2016/17. The Trust offers a half day induction for all new Governors that includes meeting the Chair and current governors to share experience and learn about the Trust.

Contact Details

The L&D Foundation Trust's Membership
Department can be contacted on:
01582 718333 or by email:
foundationtrustmembership@ldh.nhs.uk

or by writing to:
Membership Department
Luton & Dunstable Hospital NHS Foundation Trust
Lewsey Road
Luton
LU4 0DZ

The L&D Foundation Trust's Governors
can be contacted by email:
governors@ldh.nhs.uk
(please indicate which Governor you wish to contact)

or by writing to:
(Name of Governor)*
c/o Board Secretary
Luton & Dunstable Hospital NHS Foundation Trust
Lewsey Road
Luton
LU4 0DZ

*Full list of Governors available on:
www.ldh.nhs.uk

Financial Performance Report

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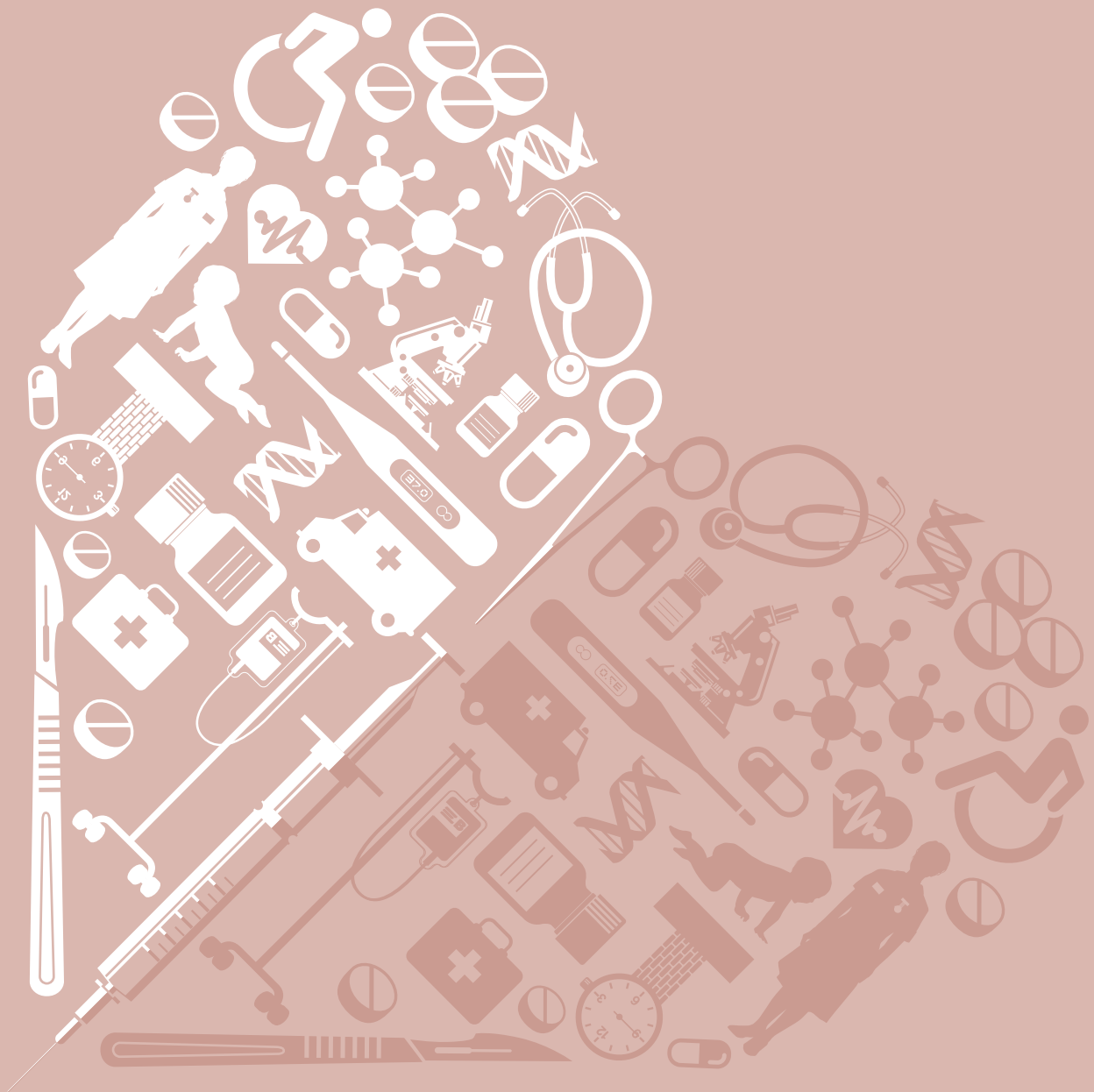

Review of Financial Performance

A financial surplus for the 17th successive year was achieved with a 2015/16 surplus of £0.1m. While our surplus is in line with our Annual Plan it relied on non-recurrent, non-cash savings to offset in particular the additional costs of temporary staffing and reflects the challenging environment in which the Trust operates.

Our staff successfully handled a range of financial pressures and challenges throughout the year. This included delivering savings to accommodate efficiency targets inherent within the national tariff system, meeting the costs of pay reform from Agenda for Change, and activity related pressure caused by both the four hour emergency care target and the 18 week elective care targets.

Furthermore the hospital was significantly challenged during the winter by record emergency attendances, a lack of community bed provision and increased demand for services that put pressures on staff and bed availability.

The table below illustrates our income and expenditure (I&E) performance since 2006/07.

	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
Turnover	153.2	169.1	189.3	204.9	211.6	220.8	230.6	244.3	259.2	**271.2**
Surplus	2.0	2.9	4.3	3.1	2.6	2.5	0.9	0.4	0.1	**0.1**
Cash	18.8	35.4	45.4	43.7	50.9	47.6	37.5	24.8	11.7	**9.1**

All figures £m

Cash balances continued to be monitored closely, with the FT ending the 2015/16 financial year with a balance of £9.1m (this was more than originally expected as capital expenditure was deferred and commissioners paid more cash to the FT than anticipated).

Given the diminishing cash balance, largely because of investment on infrastructure and the re-development of the hospital site (from £50m in FY10/11), the FT will work with NHSI & DH to secure appropriate working capital.

The FT will have spent £20.6m on capital in 2015/16 to deliver modern NHS services. In 2015/16 the FT benefitted from a £19.9m ITFF / DH loan. The FT drew down £9.5m of this loan in 2015/16 for key schemes that are designed to increase capacity and mitigate winter pressures, with the remainder, subject to appropriate approvals, dedicated to schemes in 2016/17

Scheme	Description	Link to NHS / Hospital Targets	Link to Site Development
Theatres	2 New Theatres to replace a single expensive temporary Theatre (rent £0.8m pa)	18 Week Target Demographic Growth Capacity for MK/ Bedford Review	Provide Resilience for Aging Estate Remove Capacity constraint
Increase Emergency Department Capacity &Create Orthopaedic Centre	Move Fracture Clinic out of Emergency Department (ED) to a newly created Orthopaedic Centre & create expansion capacity within ED	Maintain Achievement of the 4 hr A&E Target Cover Demographic & Non Demographic Growth (attendances increased by 12% in 14/15 alone) Capacity for MK/ Bedford Review	Remove Capacity constraint Create more Out-patient Capacity Relieve some car parking issues

Scheme	Description	Link to NHS / Hospital Targets	Link to Site Development
Ward Capacity	Create a new dedicated 30 bedded ward to meet Winter Pressures and to provide decant facility. The full year effect of Escalation areas in 14-15 was £3m largely driven by utilising 5 sub scale clinical areas. This compares with the cost of a standard 30 bedded ward of £1.5m. Refurbish existing specialist medical wards to address shortfalls in standards.	Achieve 4 hr A&E Target by ensuring patient flow maintained Cover Demographic & Non Demographic Growth (attendances to A&E increased by 12% in 14/15 alone) Capacity for MK/ Bedford Review	One of two new wards envisaged in the LDH masterplan

As the new Trust strategy emerges it will be underpinned by an updated, flexible and transparent 5 year business plan.

This plan will reflect the changing ways in which the FT will be working, acknowledging influences and expectations such as the Better Care Fund, 7 day working and the delivery of truly integrated care as well as further integration with health care partners. It will also be responsive to the means that will be adopted in rising to the associated financial challenges, abiding by the principles of economy, efficiency and effectiveness – all with the intention of protecting the resources that are available to ensure that the L&D continues to be able to deliver the highest possible level of quality healthcare in the most appropriate environment.

Looking forward, it is expected that the new financial year will be significantly more challenging and it is vital that sound financial management continues to be exercised as the Trust enters a year in which the NHS faces a substantial resource challenge.

Going Concern

The FT is facing, along with all other providers, a challenging financial environment. The FT has, however, submitted a surplus plan for 2016/17 to NHS Improvement, albeit one that contains risk and requires support / intervention from NHSI to deliver the plan or support to secure appropriate working capital. After due consideration, and noting that the FT will require support/intervention from NHSI, the Directors have a reasonable expectation that the Trust has adequate resources to continue in operational existence for the foreseeable future. For this reason, they continue to adopt the going concern basis in preparing the annual accounts.

Key Variances from the Plan in 2015/16

The Board of Directors continued to review the position of the hospital site developments in 2015/16. In order to achieve increased value for money, operational efficiency and effectiveness, it was determined that a more considered approach to major investment was required – particularly in light of the challenges facing the NHS. Accordingly the Board will receive a final business case in 2016/17 to take forward a major development of the Lewsey Road site.

During 2015/16 the Board became aware that the anticipated demand management initiatives identified by commissioners were not materialising as expected. This meant that the Trust was required to increase staffing to accommodate patient need. This led to a substantial unplanned agency pay bill (which was only partly mitigated by extra Government funding for winter pressures). Accordingly this unplanned cost reduced the level of potential surplus in 2015/16.

Principal Risks and Uncertainties facing the Trust

In 2015/16 the Trust was disadvantaged by the twin impact of reduced income (as a result of the tariff decreasing) and unavoidable inflationary cost pressures. These two factors working in tandem required the Trust to improve efficiency by 4% per annum (£10m).

During 2015/16 the FT encountered significant growth in emergency activity. This increase in patients has been contrary to CCG expectations and undermined CCG QIPP plans. The mismatch between CCG anticipated patient numbers and actual growth in patient activity in 2015/16 has given rise to substantial over-performance within the contract, and substantial Trust costs.

The impact of contract over-performance forced our main commissioner into financial deficit and in turn to challenge a variety of billed items in an attempt to mitigate their financial loss. This delayed the agreement of the 2015/16 contract value.

All 5 of the L&D main commissioners have benefitted from both growth per capita and overall growth on their CCG allocations for 2016/17:

	CCG Allocations	
	Per capita growth	Overall growth
Luton	6.2%	7.5%
Bedfordshire	8.4%	9.6%
Milton Keynes	4.6%	6.0%
E&N Herts	5.6%	6.6%
Herts Valley	5.5%	5.6%

Whilst the allocations settlement is good news, both Luton & Bedfordshire CCGs have significant underlying deficits. These deficits have, in part, been caused by an acknowledged underfunding. The impact of CCG allocation realignment will, in time, increase the CCG allocation. Notwithstanding the ultimate benefit of 'fair shares' funding, the CCGs will, it is believed, continue to seek downward pressure on providers as they seeks to redress the short term funding challenge and contribute to the Better Care Fund.

A plan designed to deliver our financial strategy has been developed. This contains more risk than has been evident in previous years and places emphasis on the abilities of the Trust's Management Team to deliver improved financial performance whilst maintaining operational targets and requires assistance from NHSI to achieve some of the savings initiatives.

The belief that appropriate clinical outcomes, patient experience and safety remain the highest priorities has continued to be maintained, as well as the recognition that this must be balanced with the requirement to achieve year-on-year efficiency savings.

Another risk for the Trust is the lack of community provision of nursing, intermediate care and rehabilitation beds, and how this impacts on our ability to safely discharge patients from hospital to appropriate facilities. The Trust is working with Clinical Commissioning Groups to resolve these issues as soon as possible.

Commissioning aspirations for the provision of care closer to home provides us with challenges and opportunities but also uncertainty with regards to the potential tendering of services.

Remuneration report

The Remuneration Committee is a Standing Committee of the Board of Directors which is appointed in accordance with the constitution of the Trust to determine the remuneration and any other associated payments or terms of service of the Executive Directors. This also includes reimbursement of travelling and other expenses incurred by Directors. The Committee meets, as a minimum, twice yearly.

The membership of the Committee includes the Trust Chairman and all Non-Executive Directors. The Chief Executive and the Director of Human Resources are also in attendance. The Director of Human Resources is present to provide advice and services to the Committee that materially assist them in the consideration of the matters before them, other than consideration of their own remuneration or performance.

Strategy and business planning process sets key business objectives which in turn inform individual objectives for senior managers. Performance is closely monitored and discussed through both an annual and an ongoing appraisal process.

The remuneration of individual Directors can be found in note 4.9 to the accounts.

There were no pay inflation increases for 2015/16.

Assurance on Very Senior Managers (VSM) Pay

The Trust has processes in place to provide assurance on VSM.

The Trust:

- Provided a report to Monitor on the 6th July 2015 detailing the managers receiving a salary above that of the Prime Ministers of £142,500.
- Completed the annual benchmarking exercise though NHS Providers that did not identify the Trust as an outlier.
- Non-Executive Director Remuneration and Nomination Committee Reporting to the Board of Directors agreed in November 2015 that a Hay review will be completed in 2016.

The Remuneration Committee does not determine the terms and conditions of office of the Chairman and Non-Executive Directors. These are decided by the Council of Governors at a separate Remuneration Committee.

Pauline Philip
Chief Executive
Date: 25th May 2016

Fundraising and Charitable Donations

During the 2015/16 financial year the Luton and Dunstable Hospital Charitable Fund received £448,770 from 1118 donations from grant-giving trusts, companies, individuals, community groups and legacies.

Of the £448,770 income, 41% was from individuals, 36% from legacy donations, 12% was from community groups, 7% of income was from Charitable Trusts and 4% was from companies.

We have separated the legacy income from individuals this year, to evaluate growth going forward in this area. Legacy donations totalled £160,873, received from three separate legacies gifted to benefit the hospital's general fund and also the Neonatal Intensive Care Unit parent's accommodation. Legacies play a key part in shaping the Hospital for future generations. We finalised and distributed our new legacy leaflets in February based on feedback from the prototype created last year. These have been circulated throughout the hospital, and posted to local solicitors and funeral homes. They have received a positive response from local solicitors; some have agreed to champion us to their legacy clients.

The Friends of the Hospital have continued their kind support towards the hospital and donated £31,285. This has been used to buy medical equipment for various wards and departments including new saddle seats for Breast Screening and specialist surgical equipment.

The NICU (Neonatal Intensive Care Unit) Appeal still has a lot of support from the local community, current and past patients. It has received 233 donations during 2015/2016 totalling £89,054. An additional £2,745 was raised to support the NICU from a golf day and £29,587 has been donated specifically to finalise and help support running costs on the new overnight facilities for parents with a baby in NICU. The new accommodation was opened in July 2015 and has been in constant use.

The NICU Appeal has raised over £1 million since the appeal was launched in 2008.

This year, we were able to finalise funding for the Maternity Bereavement Suite, creating a more homely space for families to deliver and spend time with their baby born sleeping. We held a thank you opening event in March 2016 for this.

All of the 2015 Christmas campaigns fundraising income was allocated to the Parents Facilities. Light up a Life raised £4,237 in 2015 which is almost £1,000 more than previous years. We also ran the Give a Gift campaign where people donate presents for patients through our online wish lists. Over 400 gifts were bought in total and a number of companies also came in with additional presents for patients.

The paediatric wards requested some new equipment to support their teenage patients. We put in a request to Amazon who donated £5000 worth of items to the paediatric wards. We have worked together with HBB bikers and local supermarkets to secure over 600 Easter eggs for patients.

On behalf of all the staff, patients and their families the Trust would like to say a huge thank you to everyone who has supported the hospital by making a donation, giving gifts or volunteering their time. Your support makes a real difference to our patients and their families and helps make a difficult time more comfortable and less distressing.

For more details about how to get involved with fundraising or to find out more about specific projects and what donations are spent on please contact the Fundraising Team on 01582 718 043 or email fundraising@ldh.nhs.uk

The Luton and Dunstable Hospital Charitable Fund is a registered charity in England and Wales number: 1058704

Property Plant and Equipment and Fair Value

As stated in note 1.5 to the accounts, Property Plant and Equipment are stated at Fair Value which is defined as the lower level of replacement cost and recoverable amount. A review is carried out each year for any potential impairment, with a formal revaluation every five years. A full property valuation as at 31 March 2015, was undertaken by Gerald Eve LLP. The Directors' opinion is that there are no fixed assets where the value is significantly different from the value included in the financial statements.

External Auditor

KPMG LLP (UK) is our external auditor. The appointment was made and approved following a presentation by the Chair of the Audit Committee to the Council of Governors.

KPMG LLP (UK) may, from time to time, be asked to carry out non-audit work. The cost of these other services is shown in note 5.5 to the accounts. It is important to ensure that any additional services provided by the external auditors do not impact on their ability to be independent of management, and that conflicts with objectivity do not arise. We will develop a protocol through the Audit and Risk Committee to address this. This protocol will need to be approved by the Council of Governors.

Private Finance Initiatives (PFI Schemes)

We have two capital schemes arranged under the PFI:

1. St Mary's Wing scheme was completed in 2003 under a 27 year scheme with 14 years remaining.

2. The electronic patient record scheme is a 10 year scheme that has now completed.

There were no new PFI schemes in the year and any future schemes are unlikely as they would be funded either through internally generated resources or external financing using the additional freedoms granted to Foundation Trusts.

Better Payment Practice Code

We are continuing to maintain cash balances within the needs of our suppliers, settling 90% of non-NHS invoices within 30 days of receipt of a valid invoice.

2015/16	Number of invoices	Value £000s
Total Non-NHS trade Invoices paid in the year	83,883	£110,695
Total Non-NHS trade Invoices paid within target	75,486	£93,892
Percentage of Non-NHS trade Invoices paid within target	90%	85%

Off Payroll Engagements

NHS Foundation Trusts are required to disclose the information in the tables below about off-payroll engagements.

Table 1: For all off-payroll engagements as of 31 March 2016, for more than £220 per day and that last for longer than six months

No. of existing engagements as of 31 March 2016	2
Of which...	
No. that have existed for less than one year at time of reporting.	1
No. that have existed for between one and two years at time of reporting.	
No. that have existed for between two and three years at time of reporting.	1
No. that have existed for between three and four years at time of reporting.	-
No. that have existed for four or more years at time of reporting.	-

All existing off-payroll engagements, outlined above, have at some point been subject to a risk based assessment as to whether assurance is required that the individual is paying the right amount of tax and, where necessary, that assurance has been sought.

Table 2: For all new off-payroll engagements, or those that reached six months in duration, between 1 April 2015 and 31 March 2016, for more than £220 per day and that last for longer than six months

No. of new engagements, or those that reached six months in duration, between 1 April 2015 and 31 March 2016	1
No. of the above which include contractual clauses giving the trust the right to request assurance in relation to income tax and National Insurance obligations	1
No. for whom assurance has been requested	0
Of which...	
No. for whom assurance has been received	-
Number for whom assurance has not been received	-
No. that have been terminated as a result of assurance not being received.	-

Table 3: For any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2015 and 31 March 2016

No. of off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, during the financial year.	0
No. of individuals that have been deemed "board members and/or senior officials with significant financial responsibility" during the financial year. This figure should include both off-payroll and on-payroll engagements	16

Counter Fraud

The Trust has a counter fraud policy for dealing with suspected fraud and corruption and other illegal acts involving dishonesty or damage to property. Nominated staff whom Trust staff can contact confidentially are the Director of Finance and the Local Counter Fraud Specialist (LCFS). The LCFS provides reports quarterly to our Audit and Risk Committee.

Data Loss

All Health, Public Health, Adult Social Care services and commissioned NHS service providers are required to use the Information Governance Incident Reporting Tool for reporting a level 2 IG Serious Incident. This tool is part of the online Information Governance (IG) Toolkit system. The level of an IG incident is determined by sensitivity factors. As part of this reporting requirement all organisations are also required to complete and publish the tables below with information in relation to level 1 and level 2 IG incidents.

Level 1 = Confirmed IG Serious Incident but no need to report using the IG Toolkit.

Level 2 = Confirmed IG Serious Incident that must be reported to ICO, DH and other central bodies by reporting it on the IG Toolkit. A level 2 IG SIRI can be defined as a personal data breach (as defined in the Data Protection Act), so reportable to the ICO, or high risk of reputational damage.

Level 1 Serious Incident Table:

Summary of other personal data related incidents in 2015-16

Category	Breach Type	Total
A	Corruption or inability to recover electronic data	0
B	Disclosed in Error	4
C	Lost in Transit	0
D	Lost or stolen hardware	0
E	Lost or stolen paperwork	0
F	Non-secure Disposal – hardware	0
G	Non-secure Disposal – paperwork	0
H	Uploaded to website in error	0
I	Technical security failing (including hacking)	0
J	Unauthorised access/disclosure	0
K	Other	0

Level 2 Serious Incident Table:

Summary of incident requiring investigations involving personal data as reported to the information commissioner' office in 2015/16

Date of Incident (Month)	Nature of Incident	Nature of data involved	Number of data subjects potentially affected	Notification steps
No level 2 incidents to report.				

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Statement of the Chief Executive's Responsibilities

as the Accounting Officer of Luton and Dunstable University Hospital NHS Foundation Trust

The NHS Act 2006 states that the chief executive is the accounting officer of the NHS foundation trust. The relevant responsibilities of the accounting officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the NHS Foundation Trust Accounting Officer Memorandum issued by Monitor.

Under the NHS Act 2006, Monitor has directed Luton and Dunstable University Hospital NHS foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of directed Luton and Dunstable University Hospital NHS foundation Trust and of its income and expenditure, total recognised gains and losses and cash flows for the financial year.

In preparing the accounts, the Accounting Officer is required to comply with the requirements of the ***NHS Foundation Trust Annual Reporting Manual*** and in particular to:

- observe the Accounts Direction issued by Monitor, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;
- make judgements and estimates on a reasonable basis;
- state whether applicable accounting standards as set out in the NHS Foundation Trust Annual Reporting Manual have been followed, and disclose and explain any material departures in the financial statements;
- ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance; and
- prepare the financial statements on a going concern basis.

The accounting officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS foundation trust and to enable him/her to ensure that the accounts comply with requirements outlined in the above mentioned Act. The Accounting Officer is also responsible for safeguarding the assets of the NHS foundation trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in Monitor's ***NHS Foundation Trust Accounting Officer Memorandum.***

Pauline Philip
Chief ExecutiveSigned
Date: 25th May 2016

Annual Governance Statement 2015/16

Scope of responsibility

As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS foundation trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS foundation trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the NHS Foundation Trust Accounting Officer Memorandum.

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Luton and Dunstable University Hospital NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Luton and Dunstable University Hospital NHS Foundation Trust for the year ended 31 March 2016 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

The Chief Executive is accountable for managing risk and leads the Executive Board, attends each of the Sub-Committees of the Board and the Clinical Operational Board to ensure that the Trust has robust processes in place to manage risk.

The Board leads for Risk Management are the Chief Medical Advisor and the Chief Nurse. The Managing Director is the Board lead for non-clinical (including Health and Safety) risk management. The Chief Medical Advisor leads on clinical risk management and chairs the Clinical Risk Management Committee where all aspects of clinical risk management are discussed. A report is provided to the Clinical Operational Board and assurance is then provided to the Clinical Outcome, Safety and Quality Committee and the Audit and Risk Committee. The Clinical Operational Board includes a high level Executive membership and includes the clinical medical consultant leadership though the Divisional Directors. The Divisional Directors are accountable for ensuring risk is embedded within their Divisional Boards.

All risks are reviewed by the Executive that demonstrates top level leadership to risks by considering and approving all new risks to the risk register.

At induction, new joiners to the organisation undergo basic training in risk management (clinical and non-clinical).

Risk management training sessions are provided to staff as required.

Liaison with Divisional Directors ensures that when practice is changed as a result of integrated learning from the risk management process, this is cascaded to Divisions. This takes place through the Clinical Operational Board and the Divisional Board meetings.

The Trust Risk Register is developed from risks identified at the Board of Directors and its sub committees and at divisional and department level plus from those identified from other sources e.g. external reports. The Board ensures action is taken to mitigate any risks to quality. Risks and benefits to quality and safety are assessed for all reviews of efficiency related initiatives. The Board receives the Board Assurance Framework every four months and reviews a summary of the risk register every two months in order to be able to maintain understanding of the current and future risks. The Board has participated in seminars which help in the identification of future external risks to quality such as new national guidance, new technologies and business continuity.

The risk and control framework

Risk continues to be managed at all levels of the Trust and is co-ordinated through an integrated governance framework consisting of performance and assurance processes. The Executive Board and the Clinical Operational Board lead the review of risk through the Divisional, Information Governance and Equality and Diversity sub Boards. The Board of Directors lead the review of board level strategic risk seeking assurance from the Audit and Risk, Clinical Outcome, Safety and Quality; and Finance, Investment and Performance Committees.

The Risk Management Strategy continues to provide an integrated framework for the identification and management of risks of all kinds, whether clinical,

organisational or financial and whether the impact is internal or external. This is supported by a Board Assurance Framework, which is used to record corporate objectives, risks to their achievement, key risk controls, sources of assurance and gaps in assurance to ensure effective risk management.

There is a Risk Review process under the leadership of the Executive Directors, who are consulted to approve any new risks that have been identified through the Divisions, Corporate Services or Committees and reported through the central risk register database (Datix). The relevant Executive Director agrees whether the risk is a Strategic Board Level Risk that has implication to the achievement of the Trust Objectives, review the assessment score and also allocate the risk to the relevant Sub-Committee for assurance and operational board for performance monitoring. The closed risks are also monitored to ensure the Executive Team is aware of risk amendments. The Trust has in place a weekly Senior Staff Committee that overseas operational risk.

The assessment and subsequent management of risk is informed by its quantification using a risk grading matrix, which is set by the Board of Directors. Consequence and likelihood tables are outlined in the Risk Management Framework across a range of domains; the consequence tables grade each risk by reference to its expected impact. This, combined with the likelihood score, defines a measure of overall risk. The Trust risk tolerance is set by considering all risks through the Risk Review Group and identifying those risks that have implications to the achievement of the Trust Objectives. Any of these Board Level Risks that are rated as a high risk are reported to the Board of Directors every two months. Actions and timescale for resolution are agreed by the risk leads and monitored by the Board of Directors and relevant sub-committee. Through this process, the Board are informed of any risks that would require acceptance as being within the Trust's risk tolerance.

The organisations major risks are detailed on the Trust Risk Register and Assurance Framework. Through the annual planning, the risks are formulated into five elements and the risks linked to those and their mitigating action are documented below. The Risk Register is reviewed by the Board of Directors, Audit and Risk Committee, Clinical Outcome, Safety and Quality Committee, FIP, and Executive Board, it contains in year and future risks.

L&D Top 5 Risks 2015 – 2016 (Summary)

Risk Type	Risk description	Impact	Likelihood	Mitigating actions	Monitoring Framework
Clinical Operational	1. Workforce Pressures 2. Increased emergency pressures 3. Implementation of integrated care 4. The need for robust and whole system working	High	High	Workforce plans in place Board approved action plans with Trust partners where appropriate Re-engineering programme managed by an Executive Director	Weekly Senior Team and Executive meetings Monthly Clinical Outcomes, Safety & Quality Committee
Finance	Delivering the financial challenge in 2015/16 including Commissioner plans, agency spend, CQUIN and Re-engineering programmes	High	High	Monthly review of key income, expenditure, capex, cash, balance sheet and quality performance metrics Monthly performance review meeting with Divisions led by Executive Directors Monthly Re-engineering Boards	Monthly reports of cumulative financial performance incorporating clear forecasting and an alert mechanism to identify issues that allow corrective action Monthly Finance, Investment & Performance committee review

Risk Type	Risk description	Impact	Likelihood	Mitigating actions	Monitoring Framework
				Enhanced process for business case preparation and evaluation	Executive oversight group to monitor re-engineering milestones
Present Hospital Campus	Trust site may not be consistent for optimum patient care Sustainability and Transformation Plan(STP) may impact on the Trust plans	High	High	Robust management and governance arrangements in place to manage ongoing risks and hospital re-development project Leading role in STP governance	Board review of Full Business Case and approval of actions arising from STP process
Legislation/ Target/ Regulation/ Patient Safety	Maintaining compliance against CQC outcomes, national and contractual targets and legalisation	High	Moderate	Board approved action plans in place	Regular monitoring / Assurance from Board Sub-Committees
Business Continuity	The Trust needs to be able to function in the event of a major or catastrophic event	High	Low	Ensure that the Emergency and Business Continuity plans are frequently reviewed, communicated and understood by key staff	Ongoing review and testing of Business Continuity plan relevant adaptation of plans Oversight by Board Sub group

Incident reporting is actively promoted and encouraged across all directorates as part of the culture of the organisation. The Trust actively promotes a culture of 'fair blame' or 'just blame', to encourage staff to report incidents. Incidents that have a significant impact on the Trust, its business or an individual are immediately and thoroughly investigated and the lessons learnt are shared across the Divisions.
Risks to data security are managed through a security risk register and through incident reporting. Mitigating actions are reviewed through the Information Governance Steering Group and reports to the Executive Board.

Risk Management is an embedded activity of the organisation and can be demonstrated through a number of examples:

- Each Divisional Board reviews reported incidents and are required to report to the Clinical Operational Board and reflect on the issues raised, develop any further controls to manage the principal risks and to minimise, as far as reasonably practical, the incident occurring again. If there is a persistent risk issue identified from the incident, the issue is evaluated through the Risk Register and also subjected to independent scrutiny (for example: internal audit, external accreditation)
- Risk management is integrated into core Trust business in relation to equality impact assessments. All policies and procedures when created or reviewed have to include an Equality Analysis Form. If there are any negative impacts on a particular group of people/ equality group following the completion of this form, the Trust will record any changes to the service and/ or policy. Any actions will be integrated into existing service planning and performance management frameworks along with monitoring and review processes.
- Business cases include a risk analysis both financially and clinically.

During the coming year the Trust will continue to embed a culture of external review and engagement of independent expertise to facilitate greater objectivity and learning;

- During the year in addition to using the services of internal and external audit, a number of specific reviews were commissioned. This practice will continue in 2016/17 and include an independent Board Evaluation.
- An external review of the Trust 's approach to reviewing Hospital Standardised Mortality Ratio was undertaken to provide assurance to the Board.

The Luton and Dunstable University Hospital NHS Foundation Trust is fully registered with the CQC and its current registration is **Registration without Conditions.**

No enforcement action has been taken against the Trust during the reporting period April 1st 2015 and 31st March 2016 and we have not participated in special reviews or investigations by the CQC during the reporting period.

The Care Quality Commission's team of inspectors visited the hospital over three days in January 2016 in addition to two unannounced visits to formally inspect and assess the quality of the care the Trust provides. We are expecting the report in May 2016.

The CQC monitor, inspect and regulate care services to ensure patients receive safe, effective, compassionate, high quality care. To really measure the patient's experience of care, they have identified five key questions based on the things that matter to patients. The CQC will ask these questions of every service.

- **Are they safe?** By safe we mean people are protected from physical, psychological or emotional harm. For example are people getting MRSA because of poor hygiene?

- **Are they effective?** By effective we mean that people's needs are met and their care is in line with nationally recognised guidelines and relevant NICE quality standards or effective new techniques are used to give them the best chance of getting better. For example is there an effective 'enhanced recovery' programme?

- **Are they caring?** By caring we mean that people are treated with compassion, respect and dignity and that care is tailored to their needs.

- **Are they responsive to people's needs?** By responsive we mean that people get the treatment and care at the right time without excessive delay.

- **Are they well-led?** By well led we mean that there is effective leadership, governance (clinical and corporate) and clinical involvement at all levels of the organisation and an open, fair and transparent culture that listens and learns and that there is a clear programme of improvement.

We have in place a CQC self assessment programme for all wards and clinical areas. This involves a three month cycle of self assessment, peer assessment and external peer assessment to support the delivery of performance and the implementation of corrective action in a timely manner. We have reviewed our CQC assessment programme to reflect the revised CQC inspections and these assessments are reported to each Board of Directors meeting.

Non-Executive Assessments (3x3)

The assessment process is further enhanced by Executive and Non-Executive Directors participating in our 3 x 3 initiative. The 3 x 3 initiative requires them to spend 3 hours every 3 months in a clinical setting working with staff to review their performance against CQC standards.

Transforming Quality Leadership 'Buddy' System

We implemented a programme of quality reviews with the leadership team to assess quality across the Trust services. Leaders within the organisation were assigned a 'buddy' area and were required to complete weekly visits and escalate any issues. This process provided board to ward reviews and also supported staff to raise concerns and issues to the management team. It also supported a key part of the Trust preparation for the CQC inspection. This programme has developed into a revised quality monitoring framework.

The Trust promotes the involvement of patient representatives to ensure the quality of performance data and to triangulate feedback and reviews in many aspects of its activities. Patients and Governors are represented on the following committees:

- Equality and Diversity Committee
- Clinical Audit and Effectiveness Committee
- Patient and Public Participation Group
- PLACE (Patient Led Assessment of the Care Environment)
- Ethics Committee
- Transforming Outpatients
- Hospital Re-Development Board
- Car Parking Working Group
- Re-Engineering Group
- Safeguarding Adults
- Carbon Management

Healthwatch monitor the services provided by the Trust and report directly to the Chief Executive and these are then referred to appropriate Directorate for consideration and action. Representatives from Luton Healthwatch are members of the Trust's Patient and Public Participation Group. The National Patient Survey

action plan is also progressed and monitored through this group. Healthwatch have been involved in the development and assurance of the Quality Accounts.

Since becoming a Foundation Trust the organisation has extended the involvement of staff and the public by creating a Council of Governors. The Council of Governors is responsible for a wide range of duties including, but not exclusively, being consulted on health service changes, meeting with members in their constituency, appointing and holding to account the Chair and Non-Executive Directors and attending Council of Governors' meetings. The Governors include representatives from other key stakeholders such as the CCG's, Local Government Councils and Universities.

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with.

The foundation trust has undertaken risk assessments in accordance with emergency preparedness and civil contingency requirements, to ensure that the organisation's obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with. Delivery of the Carbon Management Plan is ongoing: the Trust reports on progress with carbon reduction within the Operational Performance section of this report.

Review of economy, efficiency and effectiveness of the use of resources

In addition to the financial review of resources within the quarterly monitoring returns to Monitor and the monthly financial information provided to all budget holders, the processes that have been applied to ensure resources are used economically, efficiently and effectively include the below departments and groups. The Trust has governance arrangements for the Finance, Investment and Performance Committee with Divisions presenting directly to the committee on a range of financial and operational matters.

A Clinical Audit and Effectiveness Department is also maintained to:

- Oversee the implementation of National Institute of Clinical Effectiveness (NICE) guidance.
- Monitor the introduction of new techniques ensuring clinical and cost effectiveness of new treatments, as well as the appropriate training of clinicians.
- Support clinical audit work within the Trust, ensuring clinicians work in the most effective way, adopting good practice uniformly across the Trust through protocols and guidelines.

The use of management groups charged with monitoring efficiency and effectiveness as part of their terms of reference:

- The Medical Equipment Group advises on the replacement and purchase of new medical equipment.
- The Medicines Management Group oversees the maintenance and development of the drug formulary to ensure clinically appropriate and cost effective use of medicines.

The Trust's efficiency is quantified annually through the national reference costs exercise. The latest published index for the Trust is 89 (based on 2014-15 accounts and activity published November 2014) compared to a national average index of 100.

The Trust is also engaging in a range of benchmarking exercises to determine best practice and assess the means of implementing it at the Luton and Dunstable.

Information Governance

The Trust has had no serious information governance incidents in relation to a confidentiality breach.

Annual Quality Report

The Directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 to prepare Quality Accounts for each financial year. Monitor has issued guidance to NHS foundation trust boards on the form and content of annual Quality Reports which incorporate the above legal requirements in the ***NHS Foundation Trust Annual Reporting Manual.***

The Quality Account is the responsibility of the Chief Nurse supported by all of the Executive Team and is written following guidance issued by Monitor. Processes put in place via the Information Governance Toolkit, led by the Director of Information Technology, as Senior

Information Risk Owner (SIRO), provides assurance that the Trust's Data Quality is reviewed and monitored.

For 2015/16 the Chief Executive and Chief Nurse engaged with Trust staff and Trust Governors to review the indicators and priorities that the Trust should focus on and develop indicators on into next year.

Through the Information Governance Toolkit, the Trust has a number of key information policies in place including data quality that sets out the roles and responsibilities.

The Trust has three reports that feed data into the Board of Directors; the Quality and Performance Report, Finance Report and Workforce Report. Each of these contains data that is tracked over months and years to identify variances.

The Trust monitors Dr Foster alerts through the Mortality Board, Clinical Operational Board and Clinical Audit and Effectiveness Committee. Clinical Audit forward plans detail the work undertaken to review the data quality of these alerts. Annually the Trust has an external audit of clinical coding that demonstrated excellent practice and an external expert review of Information Governance that demonstrates assurance against the Information Governance Toolkit that includes Data Quality.

The Trust reviews directorate dashboards e.g. maternity to collect data at source and monitors the effectiveness of central data through the SUS (Secondary Uses Service) reports. The Trust monitors key performance indicators in relation to data quality that demonstrates improving practice across the Trust.

18 week data is generated by the Information Department on a weekly and monthly basis and then actively used by key departments to manage the patient's pathways so that patients receive treatment within 18 weeks of referral. Although initial checks are made by the Information Department, this data is further validated by our separate 18 week team who interrogate the files and physically track the patient's pathway on our current IT systems and record comments regarding the progress of the pathway. Inputting of the 18 week data is restricted to a core team to reduce the risk of inaccurate data entry and the further weekly validation allows for any errors to be rectified immediately. Weekly graphs are produced which are cascaded to a wider senior team both specifically around waiting list demand and 18 week performance, both which are able to highlight data discrepancies should they arise. A fortnightly meeting also interrogates the Flash report which details the 18 week patients at specialty level.

Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS foundation trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the content of the quality report attached to this Annual report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, the Audit and Risk Committee and Clinical Outcome, Safety and Quality Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The process for maintaining and reviewing the effectiveness of the system of internal control during 2015/16 was monitored by the following:

- The Board of Directors – The Board places reliance upon the Audit and Risk Committee for assurances that the system of internal control is sound.

- The Audit and Risk Committee – The function of the Audit and Risk Committee is to ensure an adequate and effective operation of the Trust's internal control system. The committee focuses on the establishment and maintenance of controls designed to give reasonable assurance that assets are safeguarded, waste and inefficiency avoided, reliable information produced and that value for money is continuously sought.

- The structure of the Board of Directors meetings during 2015/16 allows the appropriate time to ensure matters regarding Performance and Quality would be managed through the whole Board

- The Clinical Outcome, Safety and Quality Committee focus on assurance issues relating to clinical and corporate governance, risk management and assurance framework and report monthly to the Board. This committee is supported by the Clinical Operational Board that ensures divisional clinical leadership. The COSQ committee also receive assurance against the Care Quality Commission Quality Outcomes on a monthly basis.

- The Clinical Audit and Effectiveness Committee reports to the Clinical Operational Board. The committee ensures clinical leadership through the divisions, monitors the implementation of NICE guidance and reviews the Dr Foster benchmarking data sets to review trends. This process is reported to the Executive Board and assurance provided to the Clinical Outcome, Safety and Quality Committee.

- The Finance, Investment and Performance Committee takes an overview of operational activity and performance against national and local targets.

- Internal Audit – Internal Audit review the system of internal control during the course of the financial year and report accordingly to the Audit and Risk Committee.

- A Provider Licence Assurance Framework was reviewed by the Audit and Risk Committee. The Trust has reviewed Governance arrangements through the assessment of the Healthy Board 2013 and the Monitor Code of Governance. These assessments have been cross referenced against the Licence requirements laid out in condition 4 of the FT Governance.

Compliance with the NHS Foundation Trust Code of Governance

It is considered that the Luton and Dunstable University Hospital NHS Foundation Trust complies with the main and supporting principles of the Code of Governance. This includes the issues of whether or not all of the Non Executive Directors are independent in accordance with code provision B.1.1. The Board has determined that all of the NEDs are independent in character and judgement.

In relation to the more detailed provisions of the Code of Governance, the Trust are compliant with the provision with the exception of section B.1.2 in that the Board does not have half the Board of Directors as Non-Executive Directors excluding the Chair. In our Constitution the Chair votes as a Non-Executive and has a casting vote.

My review is also informed by:

Internal Audit has completed reviews of key financial controls, staff rostering, estates, waiting times for MRI and Ultrasound diagnostic tests, divisional governance, learning from incidents and complaints, management of risk in relation to bed pressures, safeguarding of adults and children and governance over Cost Improvement Plans (CIPs) in 2015/16. This work has supported the Audit and Risk Committee's understanding and review of the key issues facing the Trust. Internal Audit reviews are conducted using a risk-based approach covering areas agreed as being the priority for review based on a risk assessment agreed between the Audit and Risk Committee, Management and the auditors.

The Head of Internal Audit reports that they have completed the programme of internal audit work for the year ended 31 March 2016 as amended with the agreement of the Audit and Risk Committee, with the exception of work to assist management in ensuring completeness of income for clinical activity which is in progress. Their work identified low, moderate and high rated findings but there were no critical risk rated reports in 2015/16, nor any individual findings rated critical. Based on the work that internal audit have completed, the Head of Internal Audit has concluded that governance, risk management and control in relation to business critical areas is generally satisfactory; however there are some areas of weakness and non-compliance in the framework of governance, risk management and control which potentially put the achievement of objectives at risk

The key factors that contributed to this opinion are that whilst the majority of reports did not highlight any high risk findings, the following matters were reported:

- A number of actions to be taken by the Trust to fully implement the e-rostering system effectively, some of which were contained in management's plans for future development;
- Opportunities to strengthen the incident reporting tool (Datix) to further improve the recording of learning from moderate and low harm incidents; and
- A need to focus on timely recording of safeguarding alerts onto the Trust's patient administration system. However, assurance was subsequently received at the Clinical Outcome Safety and Quality Committee that it was the low risk patient alerts that were loaded last onto the system (e.g. the unborn child in maternity) and that the Trust has more safeguards in place than other organisations.

All recommendations arising from Internal Audit's work are considered by managers and an action plan agreed. The report, action plan and subsequent progress in implementing those actions are reviewed and monitored by the Audit and Risk Committee, and where relevant also by the Clinical Outcome, Safety and Quality Committee.

The Trust has taken action throughout the year to address the issues raised through the Internal Audit process. This included:

- Improved compliance with mandatory safeguarding training and improved the Electronic Staff Record to reflect the current requirements for safeguarding training.
- Updated and approved the Safeguarding Children Policy.
- Improved timely reporting of waiting time breaches for diagnostic tests and introduced root cause analyses for any breaches.
- Initiated capacity and demand reviews for diagnostic tests.
- Implemented an e-rostering policy to maintain the consistency of approach and initiated a review of the possible auto-rostering that could be undertaken plus enhanced reporting to demonstrate roster approvals and shift patterns.
- Initiated the further implementation of a discharge hub to review the current processes and agree recommendations to strengthen the process for patients.

Conclusion

The generally sound system of internal control is supported by a robust governance structure that reviewed any identified weaknesses regularly. Some areas for action were identified during the year and immediate action taken to mitigate and resolve the concerns.

Pauline Philip
Chief Executive
Date: 25th May 2016

Independent Audit Opinion

Independent auditor's report to the council of governors of luton and dunstable university hospital nhs foundation trust only

Opinions and conclusions arising from our audit

1. **Our opinion on the financial statements is unmodified**

We have audited the financial statements of Luton and Dunstable University Hospital NHS Foundation Trust for the year ended 31 March 2016 set out on pages 114 to 154. In our opinion:

- the financial statements give a true and fair view of the state of the Group's and the Trust's affairs as at 31 March 2016 and of the Group's and the Trust's income and expenditure for the year then ended; and
- the financial statements have been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2015/16.

2. **Our assessment of risks of material misstatement**

In arriving at our audit opinion above on the financial statements the risks of material misstatement that had the greatest effect on our audit, in decreasing order of audit significance, were as follows (unchanged from 2014/15):

Valuation of land and buildings excluding dwellings £87.5 million (2014/15: £80.5 million). The risk level is ◄► (consistent) year on year

Refer to page 79 (Audit & Risk Committee Report), pages 118 to 121 (accounting policy) and pages 136 to 138 (financial disclosures).

The risk – Land and buildings are initially recognised at cost, but subsequently are recognised at current value in existing use (EUV) for non-specialised property assets in operational use, and, for specialised assets where no market value is readily ascertainable, at the depreciated replacement cost (DRC) of a modern equivalent asset that has the same service potential as the existing property. A review is carried out each year for any potential impairment, with a formal valuation every five years.

There is significant judgment involved in determining the appropriate basis (EUV or DRC) for each asset according to its degree of specialisation, as well as over the assumptions made in arriving at the valuation of the asset. In particular the DRC basis of valuation requires an assumption as to whether the replacement asset would be situated on the existing site or, if more appropriate, on an alternative site. Further, DRC is decreased if VAT on replacement costs is deemed to be recoverable. Both of these assumptions can have potentially significant effects on the valuation.

The Group operates from one site of which it holds land assets with a value of £10.6 million and buildings (excluding dwellings) with a value of £76.9 million in its Statement of Financial Position as at 31 March 2016. A full property valuation took place at 31 March 2015. The revaluation process conducted for significant land and buildings for 31 March 2016 was based on an impairment review, performed by the Director of Estates. This has not resulted in any change to the valuation of land and building assets since the prior year.

Our response – Our procedures included:

- Reviewing the completeness of the list of assets considered for impairment through reconciliations to the fixed asset register and sample testing ten blocks from floor plan to fixed asset register;
- Assessing the independence and objectivity of the Director of Estates when performing assessments, and considering their professional qualifications and sector knowledge and experience;
- Assessing the basis of the assumptions provided by the Director of Estates on impairments to land and buildings by comparing to known benchmarks and indices;
- Undertaking appropriate work to understand the basis upon which any impairments to buildings have been considered for transfers from assets under construction in the financial statements; and
- Determining whether disclosures in relation to land and buildings have complied with the requirements of the ARM.

Recognition of NHS income £246 million (2014/15: £236 million) and non-NHS Income £9 million (2014/15: £7 million). The risk level is ◄► (consistent) year on year

Refer to page 79 (Audit & Risk Committee Report), page 118 (accounting policy) and pages 126 and 127 (financial disclosures).

The risk – The main source of income for the Group is the provision of healthcare services to the public under contracts with NHS commissioners, which make up 96.5% of income from activities (2014/15: 96.9%). The Group participates in the Agreement of Balances (AoB) exercise, which is mandated by the Department of Health (the Department), covering the English NHS only, for the purpose of ensuring that intra-NHS balances are eliminated when the consolidation exercise takes place to report to the Department's Consolidated Resource Account. The AoB exercise identifies mismatches

between income and expenditure, and receivable and payable balances recognised by the Group and its counter parties at 31 March 2016.

Mis-matches can occur for a number of reasons, but the most significant arise where the Group and commissioners have not concluded the reconciliations of healthcare spells completed within the last quarter of the financial year, which have not yet been invoiced, or there is not final agreement over proposed contract penalties as activity data for the period has not been finally validated.

In addition to this patient care income the Group reported total income of £9 million (2014/15: £7 million) from non-NHS bodies. Much of this income is generated by contracts with Local Authorities and from overseas or private patients. Consequently there is a risk that income will be recognised on a cash rather than an accruals basis.

We do not consider NHS and non-NHS income to be at high risk of significant misstatement, or to be subject to a significant judgement. However, due to its materiality in the context of the financial statements as a whole, NHS and non-NHS income is considered to be one of the areas that had the greatest effect on our overall audit strategy and allocations of resources in planning and completing our audit.

Our response – Our procedures included:

- Agreeing a sample of the income recorded in the financial statements to the signed contracts in place with key commissioners, which accounted for 96.2% of the income recorded from NHS commissioning bodies;
- Investigating a sample of contract variations and seeking explanations and evidence from management;
- Inspecting third party confirmations from commissioners and other NHS counter parties, as part of the Agreement of Balances exercise, and comparing the values disclosed within their financial statements to the value of income captured in the Group's financial statements; seeking explanations and evidence for any variances over £250,000;
- Examining the basis for the Group's bad debt provision for non-NHS income and reviewing application and reasonableness of judgement and estimation in arriving at these figures and making enquiries of management whether there are any large amounts that should be provided for but are not;
- Completing testing to confirm that system generated reports accurately and completely record aged debt; and
- Testing other material NHS income and material non-NHS income (including from Local Authorities, private patients and private sector providers) and testing invoices raised to determine whether income has been recognised in the appropriate period, classified correctly within the financial statements and that cash has been received.

3. **Our application of materiality and an overview of the scope of our audit**

The materiality for the financial statements was set at £5.2 million (2014/15: £5.0 million), determined with reference to a benchmark of income from operations (of which it represents 2%). We consider income from operations to be more stable than a surplus related benchmark.

We report to the audit committee any corrected and uncorrected identified misstatements exceeding £250,000 (2014/15: £250,000), in addition to other identified misstatements that warrant reporting on qualitative grounds.

The Group has two reporting components and both of them were subject to audits for group reporting purposes performed by the Group audit team at one location in Luton and Dunstable Hospital. These audits covered 100% of group income, surplus for the year and total assets. The audits performed for group reporting purposes were all performed to materiality levels set individually for each component and ranged from £60,000 to £5.2 million.

4. **Our opinion on other matters prescribed by the Code of Audit Practice is unmodified**

In our opinion:

- the parts of the Remuneration and Staff Reports to be audited have been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2015/16; and
- the information given in the Annual Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

5. **We have nothing to report in respect of the matters on which we are required to report by exception**

Under ISAs (UK and Ireland) we are required to report to you if, based on the knowledge we acquired during our audit, we have identified other information in the Annual Report that contains a material inconsistency with either that knowledge or the financial statements, a material

misstatement of fact, or that is otherwise misleading. In particular, we are required to report to you if:

- we have identified material inconsistencies between the knowledge we acquired during our audit and the directors' statement that they consider that the Annual Report and Accounts taken as a whole is fair, balanced and understandable and provides the information necessary for patients, regulators and other stakeholders to assess the Group's performance, business model and strategy; or
- the Audit & Risk Committee does not appropriately address matters communicated by us to the audit committee.

Under the Code of Audit Practice we are required to report to you if in our opinion:

- the Annual Governance Statement does not reflect the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual 2015/16, is misleading or is not consistent with our knowledge of the Group and other information of which we are aware from our audit of the financial statements.
- the Group has not made proper arrangement for securing economy, efficiency and effectiveness in its use of resources.
- In addition we are required to report to you if:
- any reports to the regulator have been made under Schedule 10(6) of the National Health Service Act 2006.
- any matters have been reported in the public interest under Schedule 10(3) of the National Health Service Act 2006 in the course of, or at the end of the audit.

We have nothing to report in respect of the above responsibilities

Certificate of audit completion

We certify that we have completed the audit of the accounts of Luton and Dunstable University Hospital NHS Foundation Trust in accordance with the requirements of Schedule 10 of the National Health Service Act 2006 and the Code of Audit Practice issued by the National Audit Office.

Respective responsibilities of the accounting officer and auditor

As described more fully in the Statement of Accounting Officer's Responsibilities on page 100 the accounting officer is responsible for the preparation of financial statements which give a true and fair view. Our responsibility is to audit, and express an opinion on, the financial statements in accordance with applicable law and International Standards on Auditing (UK and Ireland). Those standards require us to comply with the UK Ethical Standards for Auditors.

Scope of an audit of financial statements performed in accordance with ISAs (UK and Ireland)

A description of the scope of an audit of financial statements is provided on our website at www.kpmg.com/uk/auditscopeother2014. This report is made subject to important explanations regarding our responsibilities, as published on that website, which are incorporated into this report as if set out in full and should be read to provide an understanding of the purpose of this report, the work we have undertaken and the basis of our opinions.

Respective responsibilities of the Trust and auditor in respect of arrangements for securing economy, efficiency and effectiveness in the use of resources

The Trust is responsible for putting in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources, to ensure proper stewardship and governance, and to review regularly the adequacy and effectiveness of these arrangements.

Under Section 62(1) and Schedule 10 paragraph 1(d), of the National Health Service Act 2006 we have a duty to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

Scope of the review of arrangements for securing economy, efficiency and effectiveness in the use of resources

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance on the specified criterion issued by the Comptroller and Auditor General (C&AG), as to whether the Trust has proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. The C&AG determined this criterion as necessary for us to consider under the Code of Audit Practice in satisfying ourselves whether the Trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2016.

We planned our work in accordance with the Code of Audit Practice. Based on our risk assessment, we undertook such work as we considered necessary to form a view on whether, in all significant respects, the Trust had put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources.

The purpose of our audit work and to whom we owe our responsibilities

This report is made solely to the Council of Governors of the Trust, as a body, in accordance with Schedule 10 of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Council of Governors of the Trust, as a body, those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors of the Trust, as a body, for our audit work, for this report or for the opinions we have formed.

Fleur Nieboer
for and on behalf of KPMG LLP, Statutory Auditor
Chartered Accountants
15 Canada Square, London E14 5GL
26 May 2016

Foreword to the Accounts

These accounts for the year ended 31 March 2016 have been prepared by the Luton and Dunstable University Hospital NHS Foundation Trust in accordance with paragraphs 24 and 25 of Schedule 7 to the NHS Act 2006 and are presented to Parliament pursuant to Schedule 7, paragraph 25 (4) (a) of the National Health Service Act 2006.

Pauline Philip
Chief Executive
Date: 25th May 2016

Statement of comprehensive income

		Parent (L&D NHSFT)		Group (L&D NHSFT & NHS Charitable Funds)	
		2015/16	2014/15	2015/16	2014/15
	note	£000	£000	£000	£000
Operating Income from continuing operations	2.5	**271,176**	259,342	**271,306**	259,682
Operating Expenses of continuing operations	3	**(267,385)**	(255,811)	**(268,123)**	(256,138)
OPERATING SURPLUS		**3,791**	**3,531**	**3,183**	**3,544**
Finance Costs					
Finance income	6.1	**44**	65	**135**	148
Finance expense - financial liabilities	6.2	**(811)**	(751)	**(811)**	(751)
Finance expense - unwinding of discount on provisions		**(11)**	(11)	**(11)**	(11)
PDC Dividends payable		**(2,960)**	(2,768)	**(2,960)**	(2,768)
NET FINANCE COSTS		**(3,738)**	**(3,465)**	**(3,647)**	**(3,382)**
Movement in fair value of investment property and other investments	11	**0**	0	**(164)**	238
Surplus / (deficit) from continuing operations		**53**	66	**(628)**	400
SURPLUS / (DEFICIT) FOR THE YEAR		**53**	**66**	**(628)**	**400**
SURPLUS/ (DEFICIT) FOR THE YEAR		**53**	66	**(628)**	400
Other comprehensive income					
Revaluation Impact	23	0	(2,218)	**0**	(2,218)
TOTAL COMPREHENSIVE INCOME FOR THE YEAR		**53**	**(2,152)**	**(628)**	**(1,818)**

Note: Allocation of profits for the period: This surplus is wholly attributable to the owner of the parent.

Statement of financial position

	note	Parent 31 March 2016 £000	Parent 31 March 2015 £000	Group 31 March 2016 £000	Group 31 March 2015 £000
Non-current assets					
Intangible assets	7	**264**	334	**264**	334
Property, plant and equipment	8	**115,444**	103,027	**115,444**	103,027
Other investments	11	**0**	0	**3,072**	3,208
Trade and other receivables	14	**1,492**	1,203	**1,492**	1,203
Other assets	15	**2,712**	2,848	**2,712**	2,848
Total non-current assets		**119,912**	**107,412**	**122,984**	**110,620**
Current assets					
Inventories	13	**3,210**	2,515	**3,210**	2,515
Trade and other receivables	14	**20,518**	24,888	**20,503**	24,848
Cash and cash equivalents	25	**9,146**	11,655	**9,403**	12,325
Total current assets		**32,874**	**39,058**	**33,116**	**39,688**
Current liabilities					
Trade and other payables	16	**(22,923)**	(24,456)	**(23,070)**	(24,486)
Borrowings	18	**(617)**	(185)	**(617)**	(185)
Provisions	22	**(408)**	(1,822)	**(792)**	(2,066)
Other liabilities	17	**(1,823)**	(1,851)	**(1,823)**	(1,851)
Total current liabilities		**(25,771)**	**(28,314)**	**(26,302)**	**(28,588)**
Total assets less current liabilities		**127,015**	**118,156**	**129,798**	**121,720**
Non-current liabilities					
Borrowings	18	**(20,682)**	(11,777)	**(20,682)**	(11,777)
Provisions	22	**(650)**	(749)	**(755)**	(954)
Total non-current liabilities		**(21,332)**	**(12,526)**	**(21,437)**	**(12,731)**
Total assets employed		**105,683**	**105,630**	**108,361**	**108,989**
Financed by					
Taxpayers Equity					
Public Dividend Capital		**61,512**	61,512	**61,512**	61,512
Revaluation reserve	23	**11,522**	11,522	**11,522**	11,522
Income and expenditure reserve		**32,649**	32,596	**32,649**	32,596
Others' Equity					
Charitable Fund Reserves	24	**0**	0	**2,678**	3,359
Total taxpayers & others' equity		**105,683**	**105,630**	**108,361**	**108,989**

Pauline Philip
Chief Executive
25 May 2016

The notes on pages 118 to 155 form part of the financial statements.

Statement of changes in equity

	Parent - Pre Consolidated				Group Consolidated				
	Public Dividend Capital £000	Revaluation Reserve £000	Income and Expenditure Reserve £000	Total £000	Public Dividend Capital £000	Revaluation Reserve £000	Income and Expenditure Reserve £000	Charitable Funds Reserves £000	Total £000
Taxpayers' and Others' Equity at 1 April 2015 - as previously stated	61,512	11,522	32,596	**105,630**	61,512	11,522	32,596	3,359	**108,989**
Surplus/(deficit) for the year	0	0	53	**53**	0	0	(280)	(348)	**(628)**
Revaluation Impact	0	0	0	**0**	0	0	0	0	**0**
Public Dividend Capital received	0	0	0	**0**	0	0	0	0	**0**
Other reserve movements - charitable funds consolidation adjustment	0	0	0	**0**	0	0	333	(333)	**0**
Taxpayers' and Others' Equity at 31 March 2016	**61,512**	**11,522**	**32,649**	**105,683**	**61,512**	**11,522**	**32,649**	**2,678**	**108,361**
Taxpayers' and Others' Equity at at 1 April 2014 - as previously stated	**61,168**	**13,740**	**32,530**	**107,438**	**61,168**	**13,740**	**32,530**	**3,025**	**110,463**
Surplus/(deficit) for the year	0	0	66	**66**	0	0	(186)	586	**400**
Revaluation Impact	0	(2,218)	0	**(2,218)**	0	(2,218)	0	0	**(2,218)**
Public Dividend Capital received	344	0	0	**344**	344	0	0	0	**344**
Other reserve movements - charitable funds consolidation adjustment	0	0	0	**0**	0	0	252	(252)	**0**
Taxpayers' and Others' Equity at 31 March 2015	**61,512**	**11,522**	**32,596**	**105,630**	**61,512**	**11,522**	**32,596**	**3,359**	**108,989**

Statement of cash flows

	Parent		Group	
	2015/16 £000	2014/15 £000	2015/16 £000	2014/15 £000
Cash flows from operating activities				
Operating surplus from continuing operations	**3,791**	3,531	**3,183**	3,544
Operating surplus	**3,791**	**3,531**	**3,183**	**3,544**
Non-cash income and expense:				
Depreciation and amortisation	**8,150**	8,200	**8,150**	8,200
(Gain) / Loss on disposal	**58**	(96)	**58**	(96)
Non-cash donations/grants credited to income	**(291)**	(210)	**0**	0
(Increase)/Decrease in Trade and Other Receivables	**4,103**	(6,012)	**4,081**	(5,993)
(Increase)/Decrease in Inventories	**(695)**	41	**(695)**	41
Increase/(Decrease) in Trade and Other Payables	**(2,988)**	(619)	**(2,988)**	(619)
Increase/(Decrease) in Other Liabilities	**(28)**	(396)	**(28)**	(396)
Increase/(Decrease) in Provisions	**(1,524)**	(1,584)	**(1,524)**	(1,584)
NHS Charitable Funds - net adjustments for working capital movements, non-cash transactions and non-operating cash flows	**0**	0	**155**	(128)
Other movements in operating cash flows	**(23)**	9	**(23)**	9
NET CASH GENERATED FROM OPERATIONS	**10,553**	**2,864**	**10,369**	**2,978**
Cash flows from investing activities				
Interest received	**44**	65	**44**	65
Purchase of Intangibles	**0**	(83)	**0**	(83)
Purchase of Property, Plant and Equipment	**(18,682)**	(12,914)	**(18,973)**	(13,124)
Sale of Property, Plant and Equipment	**17**	102	**17**	102
NHS Charitable funds - net cash flows from investing activities	**0**	0	**62**	482
Net cash generated used in investing activities	**(18,621)**	**(12,830)**	**(18,850)**	**(12,558)**
Cash flows from financing activities				
Public dividend capital received	**0**	344	**0**	344
Loans received from the Department of Health	**9,500**	0	**9,500**	0
Other loans received	**30**	0	**30**	0
Other loans repaid	**(4)**	0	**(4)**	0
Capital element of Private Finance Initiative obligations	**(186)**	(183)	**(186)**	(183)
Interest paid	**(50)**	(2)	**(50)**	(2)
Interest element of Private Finance Initiative obligations	**(741)**	(749)	**(741)**	(749)
PDC Dividend paid	**(2,990)**	(2,763)	**(2,990)**	(2,763)
Net cash used in financing activities	**5,559**	**(3,353)**	**5,559**	**(3,353)**
Increase/(decrease) in cash and cash equivalents	**(2,509)**	(13,319)	**(2,922)**	(12,933)
Cash and Cash equivalents at 1 April 2015	**11,655**	24,974	**12,325**	25,258
Cash and Cash equivalents at 31 March 2016	**9,146**	**11,655**	**9,403**	**12,325**

Notes to the accounts

1. Accounting policies and other information

Monitor is responsible for issuing an accounts direction to NHS foundation trusts under the NHS Act 2006. Monitor has directed that the financial statements of NHS foundation trusts shall meet the accounting requirements of the FT ARM which shall be agreed with the Secretary of State. Consequently, the following financial statements have been prepared in accordance with the FT ARM 2015/16 issued by Monitor. The accounting policies contained in that manual follow International Financial Reporting Standards (IFRS) and HM Treasury's FReM to the extent that they are meaningful and appropriate to NHS foundation trusts. The accounting policies have been applied consistently in dealing with items considered material in relation to the accounts.

Accounting convention
These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

1.1 Consolidation

The NHS Foundation Trust is the corporate trustee to Luton & Dunstable Hospital NHS Foundation Trust Charitable Fund. The foundation trust has assessed its relationship to the charitable fund and determined it to be a subsidiary because the foundation trust is exposed to, or has rights to, variable returns and other benefits for itself, patients and staff from its involvement with the charitable fund and has the ability to affect those returns and other benefits through its power over the fund.

The charitable fund's statutory accounts are prepared to 31 March in accordance with the UK Charities Statement of Recommended Practice (SORP) which is based on UK Financial Reporting Standard (FRS) 102. On consolidation, necessary adjustments are made to the charity's assets, liabilities and transactions to:

- recognise and measure them in accordance with the foundation trust's accounting policies; and
- eliminate intra-group transactions, balances, gains and losses.

The Trust does not have any other subsidiaries, associates, joint ventures or joint operations as defined under International Financial Reporting Standards.

Unless otherwise stated the notes to the accounts disclose the group position.

1.2 Income

Income in respect of services provided is recognised when, and to the extent that, performance occurs and is measured at the fair value of the consideration receivable. The main source of income for the trust is contracts with commissioners in respect of healthcare services.

Where income is received for a specific activity which is to be delivered in a subsequent financial year, that income is deferred.

Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract.

1.3 Expenditure on Employee Benefits

Short-term Employee Benefits
Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period.

Pension Costs

NHS Pension Scheme
Past and present employees are covered by the provisions of the NHS Pension Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, GP practices and other bodies, allowed under the direction of Secretary of State, in England and Wales. It is not possible for the NHS foundation trust to identify its share of the underlying scheme liabilities. Therefore, the scheme is accounted for as a defined contribution scheme.

Employers pension cost contributions are charged to operating expenses as and when they become due.

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the trust commits itself to the retirement, regardless of the method of payment.

The trust also has employees who are members of the NEST pension scheme. This is a defined contribution scheme and employers pension cost contributions are charged to operating expenses as and when they become due.

1.4 Expenditure on other goods and services

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

1.5 Property, Plant and Equipment

Recognition
Property, plant and equipment is capitalised where:

- it is held for use in delivering services or for administrative purposes;
- it is probable that future economic benefits will flow to, or service potential be provided to, the trust;
- it is expected to be used for more than one financial year;
- the cost of the item can be measured reliably; and
- the item has an individual cost of at least £5,000; or
- the item forms a group of assets which individually have a cost of more than £1,000, collectively have a cost of at least £5,000, where the assets are functionally interdependent, they had broadly simultaneous purchase dates and are under single managerial control.
- the item forms a group of assets which are the initial equipping costs of a new or reconfigured asset with a collective value of over £20,000 and the group of assets are under common managerial control.

Where a large asset, for example a building, includes a number of components with significantly different asset lives e.g. plant and equipment, then these components are treated as separate assets and depreciated over their own useful economic lives.

Measurement

Valuation
All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

All assets are measured subsequently at valuation. The carrying values of property, plant and equipment are reviewed for impairment in periods if events or changes in circumstances indicate the carrying value may not be recoverable. All property (land and buildings, excluding infrastructure assets) are restated to current value using professional valuations in accordance with IAS16 every five years. An interim valuation is also carried out.

The Trusts properties were valued on 31 March 2015 by an external valuer, Richard Ayres MRICS of Gerald Eve LLP. The total proportion of fees payable by the client during the preceding year relative to the total fee income of the firm during the preceding year are minimal. The valuations were in accordance with the requirements of the RICS Valuation – Professional Standards, January 2014 edition and the International Valuation Standards. The valuation of each property was on the basis of market value, subject to the following assumptions:

- for owner-occupied property: the property would be sold as part of the continuing business;
- for investment property: the property would be sold subject to any existing leases; or
- for surplus property and property held for development: the property would be sold with vacant possession in its existing condition.

The valuer's opinion of market value was primarily derived using:

- comparable recent market transactions on arm's length terms and;
- the depreciated replacement cost approach, because the specialised nature of the asset means that there are no market transactions of this type of asset except as part of the business or entity.

The valuations are carried out primarily on the basis of depreciated replacement cost for specialised operational property and existing use value for non-specialised operational property. The land value for existing use purpose is assessed at existing use value. For non-operational properties including surplus land, the valuations are carried out at open market value.

Assets in the course of construction are valued at cost and are valued by professional valuers as part of the five or three-yearly valuation or when they are brought into use (if of a significant value).

PFI scheme assets have been valued in accordance with the policy above.

Operational equipment is valued at depreciated historic cost. Equipment surplus to requirements is valued at net recoverable amount.

An item of property, plant and equipment which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 or IFRS 5.

Subsequent expenditure
Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the Statement of Comprehensive Income in the period in which it is incurred.

Depreciation
Items of property, plant and equipment are depreciated over their remaining useful economic lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.

Property, plant and equipment which has been reclassified as 'Held for Sale' ceases to be depreciated upon the reclassification. Assets in the course of construction and residual interests in off-Statement of Financial Position PFI contract assets are not depreciated until the asset is brought into use or reverts to the trust, respectively.

Revaluation gains and losses
Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating income. Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

Impairments
In accordance with the FT ARM, impairments that arise from a clear consumption of economic benefits or service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment that arises from a clear consumption of economic benefit or service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating income to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.

Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

De-recognition
Assets intended for disposal are reclassified as 'Held for Sale' once all of the following criteria are met:

- the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales;
- the sale must be highly probable i.e.:
  - management are committed to a plan to sell the asset;
  - an active programme has begun to find a buyer and complete the sale;
  - the asset is being actively marketed at a reasonable price;
  - the sale is expected to be completed within 12 months of the date of classification as 'Held for Sale';
- the actions needed to complete the plan indicate it is unlikely that the plan will be dropped or significant changes made to it.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'Held for Sale' and instead is retained as an operational asset and the asset's economic life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

Donated assets
Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time,

unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

Private Finance Initiative (PFI) transactions
PFI transactions which meet the IFRIC 12 definition of a service concession, as interpreted in HM Treasury's FReM, are accounted for as 'on-Statement of Financial Position' by the Trust. In accordance with IAS 17, the underlying assets are recognised as property, plant and equipment at their fair value, together with an equivalent finance lease liability. Subsequently, the assets are accounted for as property, plant and equipment or intangible assets as appropriate.

The annual contract payments are apportioned between the repayment of the liability, a finance cost and the charges for services. The service charge is recognised in operating expenses and the finance cost is charged to Finance Costs in the Statement of Comprehensive Income.

The lifecycle costs i.e. those costs anticipated to be incurred to maintain the asset to a specified standard, within the scheme form part of the liability of the Trust and consequently have been recognised as a separate asset within the Statement of Financial Position. The asset is amortised each accounting period in accordance with the lifecycle costs incurred in respect of the PFI scheme asset.

1.6 Intangible assets

Recognition
Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the trust's business or which arise from contractual or other legal rights. They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the trust and where the cost of the asset can be measured reliably.

Internally generated intangible assets
Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets.

Expenditure on research is not capitalised.
Expenditure on development is capitalised only where all of the following can be demonstrated:

- the project is technically feasible to the point of completion and will result in an intangible asset for sale or use;
- the Trust intends to complete the asset and sell or use it;
- the Trust has the ability to sell or use the asset;
- how the intangible asset will generate probable future economic or service delivery benefits e.g. the presence of a market for it or its output, or where it is to be used for internal use, the usefulness of the asset;
- adequate financial, technical and other resources are available to the Trust to complete the development and sell or use the asset; and
- the Trust can measure reliably the expenses attributable to the asset during development.

Software
Software which is integral to the operation of hardware e.g. an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware e.g. application software, is capitalised as an intangible asset.

Measurement
Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

Subsequently intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciatetd replacement cost and the value in use where the asset is income generating. Revaluations gains and losses and impairments are treated in the same manner as for Property, Plant and Equipment. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value under IFRS13, if it does not meet the requirements of IAS 40 or IFRS 5.

Intangible assets held for sale are measured at the lower of their carrying amount or 'fair value less costs to sell'.

Amortisation
Intangible assets are amortised over their expected useful economic lives in a manner consistent with the consumption of economic or service delivery benefits.

1.7 Revenue government and other grants

Government grants are grants from Government bodies other than income from clinical commissioning groups or NHS trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure.

1.8 Inventories

Inventories are valued at the lower of cost and net realisable value. The cost of inventories is measured using the First In, First Out (FIFO) method.

1.9 Financial instruments and financial liabilities

Recognition
Financial assets and financial liabilities which arise from contracts for the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements, are recognised when, and to the extent which, performance occurs i.e. when receipt or delivery of the goods or services is made.

Regular way purchases or sales are recognised and de-recognised, as applicable, using the Trade/Settlement date.

All other financial assets and financial liabilities are recognised when the Trust becomes a party to the contractual provisions of the instrument.

De-recognition
All financial assets are de-recognised when the rights to receive cash flows from the assets have expired or the Trust has transferred substantially all of the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

Classification and Measurement
"Financial assets are categorised as 'fair value through income and expenditure', loans and receivables or 'available-for-sale financial assets'.

Financial liabilities are classified as 'fair value through income and expenditure' or as 'other financial liabilities'.

Financial assets and financial liabilities at 'Fair Value through Income and Expenditure'
Financial assets and financial liabilities at 'fair value through income and expenditure' are financial assets or financial liabilities held for trading. A financial asset or financial liability is classified in this category if acquired principally for the purpose of selling in the short-term. Derivatives are also categorised as held for trading unless they are designated as hedges. Derivatives which are embedded in other contracts but which are not 'closely-related' to those contracts are separated-out from those contracts and measured in this category. Assets and liabilities in this category are classified as current assets and current liabilities.

These financial assets and financial liabilities are recognised initially at fair value, with transaction costs expensed in the income and expenditure account. Subsequent movements in the fair value are recognised as gains or losses in the Statement of Comprehensive Income.

Financial Assets

Loans and receivables
Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. They are included in current assets.

The trust's loans and receivables comprise: cash and cash equivalents, NHS debtors, accrued income and 'other debtors'.

Loans and receivables are recognised initially at fair value, net of transactions costs, and are measured subsequently at amortised cost, using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash receipts through the expected life of the financial asset or, when appropriate, a shorter period, to the net carrying amount of the financial asset.

Interest on loans and receivables is calculated using the effective interest method and credited to the Statement of Comprehensive Income. Loans from the Department of Health are not held for trading and are measured at historic cost with any unpaid interest accrued separately.

Available-for-sale financial assets
Available-for-sale financial assets are non-derivative financial assets which are either designated in this category or not classified in any of the other categories. They are included in long-term assets unless the trust intends to dispose of them within 12 months of the Statement of Financial Position date.

Available-for-sale financial assets are recognised initially at fair value, including transaction costs, and

measured subsequently at fair value, with gains or losses recognised in reserves and reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'. When items classified as 'available-for-sale' are sold or impaired, the accumulated fair value adjustments recognised are transferred from reserves and recognised in 'Finance Costs' in the Statement of Comprehensive Income.

Financial Liabilities - Other financial liabilities
"All other financial liabilities are recognised initially at fair value, net of transaction costs incurred, and measured subsequently at amortised cost using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash payments through the expected life of the financial liability or, when appropriate, a shorter period, to the net carrying amount of the financial liability.

They are included in current liabilities except for amounts payable more than 12 months after the Statement of Financial Position date, which are classified as long-term liabilities.

Interest on financial liabilities carried at amortised cost is calculated using the effective interest method and charged to Finance Costs. Interest on financial liabilities taken out to finance property, plant and equipment or intangible assets is not capitalised as part of the cost of those assets.

Determination of fair value
For financial assets and financial liabilities carried at fair value, the carrying amounts are determined from discounted cash flow analysis.

Impairment of financial assets
At the Statement of Financial Position date, the trust assesses whether any financial assets, other than those held at 'fair value through income and expenditure' are impaired. Financial assets are impaired and impairment losses are recognised if, and only if, there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in the Statement of Comprehensive Income and the carrying amount of the asset is reduced through the use of a bad debt provision.

The bad debt provision comprises of specific bad debts for known disputed items, debtors greater than one year, and debtors where there is a history of non-payment.

1.10 Leases

Finance leases
Where substantially all risks and rewards of ownership of a leased asset are borne by the NHS foundation trust, the asset is recorded as property, plant and equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease.

The asset and liability are recognised at the commencement of the lease. Thereafter the asset is accounted for an item of property plant and equipment.

The annual rental is split between the repayment of the liability and a finance cost so as to achieve a constant rate of finance over the life of the lease. The annual finance cost is charged to Finance Costs in the Statement of Comprehensive Income. The lease liability, is de-recognised when the liability is discharged, cancelled or expires.

Operating leases
Other leases are regarded as operating leases and the rentals are charged to operating expenses on a straight-line basis over the term of the lease. Operating lease incentives received are added to the lease rentals and charged to operating expenses over the life of the lease.

Leases of land and buildings
Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately.

1.11 Provisions

The NHS foundation trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. For charitable funds decisions made by the Charitable Fund Committee for which there is a constructive obligation to undertake activities are recognised at the point the decision is made.

The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using the discount rates published and mandated by HM Treasury.

Clinical negligence costs
The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the NHS foundation trust pays an annual contribution to the NHSLA, which, in return, settles all clinical negligence claims. Although the NHSLA is administratively responsible for all clinical negligence cases, the legal liability remains with the NHS foundation trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the NHS foundation trust is disclosed at note 22 but is not recognised in the NHS foundation trust's accounts.

Non-clinical risk pooling
The NHS foundation trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the trust pays an annual contribution to the NHS Litigation Authority and in return receives assistance with the costs of claims arising. The annual membership contributions, and any 'excesses' payable in respect of particular claims are charged to operating expenses when the liability arises.

1.12 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in note 27 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in note 27, unless the probability of a transfer of economic benefits is remote. Contingent liabilities are defined as:

- possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or
- present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

1.13 Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS trust. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

A charge, reflecting the cost of capital utilised by the NHS foundation trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the NHS foundation trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for (i) donated assets (including lottery funded assets), (ii) average daily cash balances held with the Government Banking Services (GBS) and National Loans Fund (NLF) deposits, excluding cash balances held in GBS accounts that relate to a short-term working capital facility, (iii) any PDC dividend balance receivable or payable. In accordance with the requirements laid down by the Department of Health (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the 'pre-audit' version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

1.14 Value Added Tax

Most of the activities of the NHS foundation trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.15 Corporation Tax

The majority of the Trust's activities are related to core healthcare and are therefore not subject to tax. Where trading activities are undertaken that are commercial in nature they are considered insignificant with profits per activity below the corporation tax threshold, as per the HMRC 'Guidance on the Tax Treatment of Non-core Healthcare Commercial Activities of NHS Foundation Trusts'.

1.16 Foreign exchange

The functional and presentational currencies of the trust are sterling. A transaction which is denominated in a foreign currency is translated into the functional currency at the spot exchange rate on the date of the transaction.

Where the Trust has assets or liabilities denominated in a foreign currency at the Statement of Financial Position date:

- monetary items (other than financial instruments measured at 'fair value through income and expenditure') are translated at the spot exchange rate on 31 March;
- non-monetary assets and liabilities measured at historical cost are translated using the spot exchange rate at the date of the transaction; and
- non-monetary assets and liabilities measured at fair value are translated using the spot exchange rate at the date the fair value was determined.

Exchange gains or losses on monetary items (arising on settlement of the transaction or on re-translation at the Statement of Financial Position date) are recognised in income or expense in the period in which they arise.

Exchange gains or losses on non-monetary assets and liabilities are recognised in the same manner as other gains and losses on these items.

1.17 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the NHS foundation trust has no beneficial interest in them. However, they are disclosed in a separate note to the accounts in accordance with the requirements of HM Treasury's FReM, see Note 25.

1.18 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled.

Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had NHS trusts not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

However the losses and special payments note is compiled directly from the losses and special payments register which reports on a cash basis with the exception of provisions for future losses, see Note 32.

2.1 Operating income (by classification)

	2015/16 Total £000	2014/15 Total £000
Income from Activities		
Elective income	**37,618**	37,541
Non elective income	**74,919**	70,454
Outpatient income	**39,460**	37,153
A & E income	**12,113**	10,344
Other NHS clinical income	**86,631**	85,308
Additional income for delivery of healthcare services	**2,000**	0
Private patient income	**1,954**	1,845
Other clinical income	**784**	741
Total income from activities	**255,479**	**243,386**

2.2 Commissioner Requested Services

The Trust's provider licence specifies the Commissioner Requested Services, for details see www.monitor.gov.uk. This note analyses income from activities between Commissioner Requested Services and Non Commissioner Requested Services.

	2015/16 £000	2014/15 £000
Commissioner Requested Services	**250,741**	240,800
Non Commissioner Requested Services	**4,738**	2,586
	255,479	**243,386**

2.3 Operating lease income

	2015/16 Total £000	2014/15 Total £000
Operating Lease Income		
Rents recognised as income in the period	**719**	701
TOTAL	**719**	**701**
Future minimum lease payments due on leases of Buildings expiring		
- not later than one year;	**220**	67
- later than one year and not later than five years;	**878**	188
- later than five years.	**920**	207
TOTAL	**2,018**	**462**

2.4 Overseas visitors (relating to patients charged directly by the NHS foundation trust)

	2015/16 £000	2014/15 £000
Income recognised this year	**96**	137
Cash payments received in-year	**83**	26
Amounts added to provision for impairment of receivables	**23**	29
Amounts written off in-year	**86**	537*

* Due to information governance concerns the Trust had been unable to refer overdue debts to a debt collection agency. This issue was resolved in 2014/15. As a result these write-offs relate to 2006/07 to 2014/15 overseas patients treatment where the debt collection agency have been unable to locate the individual.

2.5 Operating income (by type)

	Parent		Group	
	2015/16 £000	2014/15 £000	2015/16 £000	2014/15 £000
Income from activities				
NHS Foundation Trusts	**493**	729	**493**	729
NHS Trusts	**1,258**	1,250	**1,258**	1,250
CCGs and NHS England	**243,407**	232,702	**243,407**	232,702
Local Authorities	**1,632**	1,843	**1,632**	1,843
Department of Health - other	**20**	0	**20**	0
NHS Other	**470**	485	**470**	485
Non NHS: Private patients	**1,954**	1,845	**1,954**	1,845
Non-NHS: Overseas patients (non-reciprocal)	**96**	137	**96**	137
NHS injury scheme (was RTA)	**784**	741	**784**	741
Non NHS: Other*	**3,365**	3,655	**3,365**	3,655
Additional income for delivery of healthcare services	**2,000**	0	**2,000**	0
Total income from activities	**255,479**	**243,387**	**255,479**	**243,387**

*Non NHS: Other relates to contract with private sector provider, previously commissioned by NHS Bedfordshire

	Parent		Group	
	2015/16 £000	2014/15 £000	2015/16 £000	2014/15 £000
Other operating income				
Research and development	**760**	541	**760**	541
Education and training	**8,253**	8,811	**8,253**	8,811
Charitable and other contributions to expenditure	**290**	210	0	0
Received from NHS charities: Other charitable and other contributions to expenditure	**42**	42	**0**	0
Rental revenue from operating leases	**719**	701	**719**	701
Income in respect of staff costs where accounted on gross basis	**812**	986	**812**	986
Profit on disposal of other tangible fixed assets*[1]	**6**	96	**6**	96
NHS Charitable Funds: Incoming Resources excluding investment income	**0**	0	**462**	592
Other*[2]	**4,815**	4,568	**4,815**	4,568
Total other operating income	**15,697**	**15,955**	**15,827**	**16,295**
TOTAL OPERATING INCOME	**271,176**	**259,342**	**271,306**	**259,682**

*[1] profits arose from disposal of equipment, the Trust did not dispose of any property used for Commissioner Requested Services

*[2] This includes car parking income of £1,621k (2014/15 £1,456k). This is strictly an income generation activity whereby income exceeds cost and the surplus is invested in the provision of patient care. There are other Trust objectives delivered through this activity including a contribution to the patient and staff safety and experience agenda (additional security and maximising the availability of car parking spaces).

3.1 Operating Expenses (by type)

	Parent		Group	
	2015/16 £000	Restated 2014/15 £000	2015/16 £000	Restated 2014/15 £000
Purchase of healthcare from non NHS bodies	0	130	0	130
Employee Expenses - Executive directors	935	1,013	935	1,013
Employee Expenses - Non-executive directors	136	130	136	130
Employee Expenses - Staff	176,587	166,969	176,587	166,969
Supplies and services - clinical (excluding drug costs)	25,284	25,992	25,284	25,992
Supplies and services - general	5,761	5,038	5,761	5,038
Establishment	5,574	5,724	5,574	5,724
Transport	85	87	85	87
Premises*[1]	11,740	9,091	11,740	9,091
Increase / (decrease) in provision for receivable impairments	67	82	67	82
Drug costs (non inventory drugs only)	1,431	1,253	1,431	1,253
Drugs Inventories consumed	24,572	21,830	24,572	21,830
Rentals under operating leases - minimum lease receipts	1,698	1,739	1,698	1,739
Depreciation on property, plant and equipment	8,080	8,130	8,080	8,130
Amortisation on intangible assets	70	70	70	70
Audit fees payable to the External Auditor				
audit services- statutory audit*[2]	48	50	48	50
other services: audit-related assurance services'	7	7	7	7
other auditor remuneration (external auditor only)	22	11	22	11
Audit fees payable re charitable fund accounts	0	0	3	3
Clinical negligence (Insurance Premiums)	6,380	6,547	6,380	6,547
Loss on disposal of other property, plant and equipment	63	0	63	0
Legal fees	87	91	87	91
Consultancy costs	939	1,481	939	1,481
Internal Audit Costs - not included in employee expenses	80	63	80	63
Training, courses and conferences	746	448	746	448
Patient travel	197	1,284	197	1,284
Car parking & Security	693	606	693	606
Redundancy - (not included in employee expenses)	57	149	57	149
Early retirements - (not included in employee expenses)	0	26	0	26
Hospitality	7	13	7	13
Publishing	49	45	49	45
Insurance	110	114	110	114
Other services, eg external payroll	250	293	250	293
Grossing up consortium arrangements	88	94	88	94
Losses, ex gratia & special payments	9	88	9	88
NHS Charitable funds: Other resources expended	0	0	735	324
Other *[3]	(4,467)	(2,877)	(4,467)	(2,877)
TOTAL	**267,385**	**255,811**	**268,123**	**256,138**

*[1] The Trust outsourced Soft FM (Catering, Domestics) in year

*[2] Excluding non-recoverable VAT.

*[3] Negative value as a result of reversing unused provisions and accruals during 2014/15 and 2015/16.

4.1 Employee Expenses (excluding non-executive directors)

	2015/16 Permanent £000	2015/16 Other £000	2015/16 Total £000	2014/15 Permanent £000	2014/15 Other £000	2014/15 Total £000
Salaries and wages	120,911	16,032	**136,943**	115,237	16,219	**131,456**
Social security costs	10,622	1,165	**11,787**	10,094	1,283	**11,377**
Pension costs - defined contribution plans Employers contributions to NHS Pensions	14,316	633	**14,949**	13,241	605	**13,846**
Agency/contract staff	0	15,742	**15,742**	0	11,739	**11,739**
Costs capitalised as part of assets	(1,415)	(427)	**(1,842)**	(353)	(83)	**(436)**
TOTAL	**144,434**	**33,145**	**177,579**	**138,219**	**29,763**	**167,982**

4.2 Average number of employees (WTE basis)

	2015/16 Permanent Number	2015/16 Other Number	2015/16 Total Number	2014/15 Restated Permanent Number	2014/15 Restated Other Number	2014/15 Restated Total Number
Medical and dental	501	109	**610**	491	84	**575**
Administration and estates	617	101	**718**	589	93	**682**
Healthcare assistants and other support staff	652	230	**882**	649	227	**876**
Nursing, midwifery and health visiting staff	1,196	171	**1,367**	1,171	153	**1,324**
Nursing, midwifery and health visiting learners	5	0	**5**	5	0	**5**
Scientific, therapeutic and technical staff	345	8	**353**	315	8	**323**
Healthcare science staff	136	46	**182**	131	54	**185**
Other	3	0	**3**	3	0	**3**
Number of Employees (WTE) engaged on capital projects	(47)	(9)	**(56)**	(10)	(16)	**(26)**
TOTAL	**3,408**	**656**	**4,064**	**3,344**	**603**	**3,947**

4.3 Employee benefits

There were no employee benefits during either 2015/16 nor 2014/15.

4.4 Early retirements due to ill health

This note discloses the number and additional pension costs for individuals who retired early on ill-health grounds during the year. There were 3 (2014/15: 1) retirements, at an additional cost of £248k (2014/15: £89k). This information has been supplied by NHS Pensions.

4.5.1 Senior Managers Remuneration

Name	Title	2015/16 Salary (bands of £5,000)	Pension Related Benefits (bands of £2,500)	Total (bands of £5,000)
Chairman				
Simon Linnett	Chairman	40 to 45		40 to 45
Non Executive Directors				
Clifford Bygrave	Non-Executive Director (left 31/07/15)	5 to 10		5 to 10
Alison Clarke	Non-Executive Director	10 to 15		10 to 15
Ninawatie Tiwari	Non-Executive Director	10 to 15		10 to 15
John Garner	Non-Executive Director	10 to 15		10 to 15
Mark Versallion	Non-Executive Director	10 to 15		10 to 15
David Hendry	Non-Executive Director	10 to 15		10 to 15
Jill Robinson	Non- Executive Director	10 to 15		10 to 15
Executive Directors				
Pauline Philip	Chief Executive	205 to 210	n/a	205 to 210
David Carter	Managing Director	130 to 135	27.5 to 30	160 to 165
Andrew Harwood	Director of Finance	125 to 130	17.5 to 20	145 to 150
Mark Patten	Medical Director (to 30/9/15)	160 to 165	25 to 27.5	185 to 190
Danielle Freedman	Chief Medical Advisor (from 1/10/15)[1]	150 to 155	n/a	150 to 155
Patricia Reid	Director of Nursing	115 to 120	15 to 17.5	130 to 135
Angela Doak	Director of Organisational Development	120 to 125	17.5 to 20	135 to 140
Mark England	Director of Reengineering and Informatics	120 to 125	25 to 27.5	145 to 150

[1] Salary is for full 2015/16 year (including period prior to appointment as Chief Medical Advisor)

4.5.1 Senior Managers Remuneration continued

2014/15

Name	Title	Salary (bands of £5,000)	Pension Related Benefits (bands of £2,500)	Total (bands of £5,000)
Chairman				
Spencer Colvin	Chairman (left 30/06/2014)	10 to 15		10 to 15
Clifford Bygrave	Interim Chair (1/07/2014 to 23/09/2014)	10 to 15		10 to 15
Simon Linnett	Chairman (started 24/09/2014)	20 to 25		20 to 25
Non Executive Directors				
Clifford Bygrave	Non-Executive Director (excl 1/07/2014 to 23/09/2014)	10 to 15		10 to 15
Alison Clarke	Non-Executive Director	10 to 15		10 to 15
Ninawatie Tiwari	Non-Executive Director	10 to 15		10 to 15
John Garner	Non-Executive Director	10 to 15		10 to 15
Mark Versallion	Non-Executive Director	10 to 15		10 to 15
Jagtar Singh	Non-Executive Director (left 30/12/2014)	5 to 10		5 to 10
David Hendry	Non-Executive Director (started 22/10/2014)	5 to 10		5 to 10
Jill Robinson	Non- Executive Director (started 5/12/2014)	0 to 5		0 to 5
Executive Directors				
Pauline Philip	Chief Executive	205 to 210	n/a	205 to 210
David Carter	Managing Director	130 to 135	17.5 to 20	150 to 155
Andrew Harwood	Director of Finance	125 to 130	17.5 to 20	145 to 150
Mark Patten	Medical Director	160 to 165	20 to 22.5	180 to 185
Patricia Reid	Director of Nursing	115 to 120	15 to 17.5	130 to 135
Angela Doak	Director of Organisational Development	120 to 125	15 to 17.5	135 to 140
Mark England	Director of Reengineering and Informatics[1]	120 to 125	65 to 67.5	185 to 190

[1] Voting Director from 22/10/2014

For the purpose of this note Senior Managers are defined as being the Chief Executive, Non Executive Directors and Executive Directors. I.e. Those individuals with voting rights.

Senior Managers have not received any taxable benefits, annual performance-related bonuses or long-term performance related bonuses in either 2015/16 or 2014/15.

4.5.2 Pension benefits

	2015/16				
Name and title	Real increase in pension and related lump sum at age 60 (bands of £2,500)	Total accrued pension and related lump sum at age 60 at 31 March 2016 (bands of £2,500)	Cash Equivalent Transfer Value at 31 March 2016 £000	Cash Equivalent Transfer Value at 31 March 2015 £000	Real Increase in Cash Equivalent Transfer £000
Pauline Philip[1] Chief Executive	-	-	-	-	-
David Carter Managing Director	0 to 2.5	117.5 to 120	500	473	20
Andrew Harwood Director of Finance	2.5 to 5	187.5 to 190	875	840	23
Mark Patten Medical Director	0 to 2.5	160 to 162.5	731	704	17
Danielle Freedman[1] Chief Medical Advisor (from 1/10/15)	-	-	-	-	-
Patricia Reid Director of Nursing	2.5 to 5	102.5 to 105	589	550	31
Angela Doak Director of Organisational Development	2.5 to 5	175 to 177.5	798	762	25
Mark England Director of Reengineering and Informatics	0 to 2.5	15 to 17.5	181	155	24

[1] No longer contributing to pension scheme

On 16 March 2016, the Chancellor of the Exchequer announced a change in the Superannuation Contributions Adjusted for Past Experience (SCAPE) discount rate from 3.0% to 2.8%. This rate affects the calculation of CETV figures in this report.
Due to the lead time required to perform calculations and prepare annual reports, the CETV figures quoted in this report for members of the NHS Pension scheme are based on the previous discount rate and have not been recalculated.

	2014/15				
Name and title	Real increase in pension and related lump sum at age 60 (bands of £2,500)	Total accrued pension and related lump sum at age 60 at 31 March 2015 (bands of £2,500)	Cash Equivalent Transfer Value at 31 March 2015 £000	Cash Equivalent Transfer Value at 31 March 2014 £000	Real Increase in Cash Equivalent Transfer Value £000
Pauline Philip[1] Chief Executive	-	-	-	-	-
David Carter Managing Director	2.5 to 5	115 to 117.5	473	435	26
Andrew Harwood Director of Finance	0 to 2.5	180 to 182.5	840	789	30
Mark Patten Medical Director	0 to 2.5	160 to 162.5	704	655	31
Patricia Reid Director of Nursing	2.5 to 5	97.5 to 100	550	502	34
Angela Doak Director of Organisational Development	0 to 2.5	170 to 172.5	762	715	28
Mark England Director of Reengineering and Informatics	2.5 to 5	12.5 to 15	155	105	47

4.5.3 Median Pay Disclosure

Reporting bodies are required to disclose the relationship between the remuneration of the highest paid director in their organisation and the median remuneration of the organisation's workforce. Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind as well as severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.
"

	2015/16	2014/15
Band of Highest Paid Director's Total Remuneration	205 to 210	205 to 210
Median Total	**25,047**	**25,783**
Ratio	8.3	8.0

The highest paid director's remuneration did not change during 2015/16. There was a small increase in median pay due to the application of pay increases in line with national NHS contracts during the year.

4.5.4 Staff Exit Packages

	2015/16		2014/15	
Exit package cost band (including any special payment element)	Total number of exit packages	Total cost of exit packages £'000	Total number of exit packages	Total cost of exit packages £'000
<£10,000	16	52	14	28
£10,001 - £25,000	0	0	0	0
£25,001 - 50,000	0	0	1	40
£50,001 - £100,000	1	55	0	0
£100,001 - £150,000	0	0	1	109
>£150,000	0	0	0	0
Total	**17**	**107**	**16**	**177**

	2015/16	2015/16	2014/15	2014/15
	Payments agreed	Total value	Payments agreed	Total Value
	Number	£'000	Number	£'000
Voluntary redundancies including early retirement contractual costs	2	59	2	149
Contractual payments in lieu of notice	15	48	14	28
Non-contractual payments requiring HMT approval	0	0	0	0
	17	**107**	**16**	**177**

All staff exit packages were in respect of non-compulsory departures in both 2014/15 and 2015/16.

4.5.5 Expenses of Governors and Directors

The Foundation Trust had a total of 34 (46 in 2014/15) governors in office in 2015/16. 11 (9 in 2014/15) of these governors received expenses in 2015/16, with aggregate expenses paid to governors of £1,200 (£1,100 in 2014/15).

The Foundation Trust had a total of 16 (17 in 2014/15) directors in office in 2015/16. 6 (8 in 2014/15) of these directors received expenses in 2015/16, with aggregate expenses paid to directors of £2,400 (£4,100 in 2014/15)

5.1 Operating leases

	2015/16	2014/15
	£000	£000
Minimum lease payments	1,698	1,739
TOTAL	**1,698**	**1,739**

5.2 Arrangements containing an operating lease

Future minimum lease payments due:	2015/16 £000 Land	2015/16 £000 Buildings	2015/16 £000 Other	2015/16 £000 Total	2014/15 £000 Total
- not later than one year;	74	107	3	184	1,122
- later than one year and not later than five years;	295	378	0	673	738
- later than five years.	805	1,139	0	1,944	863
TOTAL	**1,174**	**1,624**	**3**	**2,801**	**2,723**

The Trust does not have any significant leasing arrangements.

5.3 Limitation on auditor's liability

There is £1m limitation on the auditors liability.

5.4 The late payment of commercial debts (interest) Act 1998

£0.1k was paid in respect of the late payment of commercial debts (interest) Act 1998 (£2k in 2014/15)

5.5 Other Audit Remuneration

£22k expenditure was incurred with the external audit provider in respect of tax advice in 2015/16. (£11k 2014/15)

5.6 Impairment of assets (PPE & intangibles)

No impairments have been charged to expenditure in either 2014/15 nor 2015/16.

6.1 Finance income

	Parent		Group	
	2015/16 £000	2014/15 £000	2015/16 £000	2014/15 £000
Interest on instant access bank accounts	**44**	65	**44**	65
Interest on held-to-maturity financial assets	**0**	0	**0**	0
NHS Charitable funds: investment income	**0**	0	**91**	83
TOTAL	**44**	**65**	**135**	**148**

6.2 Finance costs - interest expense

	Parent		Group	
	2015/16 £000	2014/15 £000	2015/16 £000	2014/15 £000
Capital loans from the Department of Health	72	0	72	0
Interest on late payment of commercial debt	0	2	0	2
Finance Costs in PFI obligations				
Main Finance Costs	739	749	739	749
TOTAL	**811**	**751**	**811**	**751**

7.1 Intangible Assets 2015/16

	Software Licenses £000	Total £000
Cost or valuation at 1 April 2015 as previously stated	536	**536**
Additions - purchased	0	**0**
Cost or valuation at 31 March 2016	536	**536**
Amortisation at 1 April 2015 as previously stated	202	**202**
Provided during the year	70	**70**
Amortisation at 31 March 2016	272	**272**
Net book value		
NBV - Owned at 31 March 2016	264	**264**
NBV total at 31 March 2016	**264**	**264**

7.2 Intangible Assets 2014/15

	Software Licenses £000	Total £000
Cost or valuation at 1 April 2014 as previously stated	536	**536**
Additions - purchased	0	**0**
Cost or valuation at 31 March 2015	536	**536**
Amortisation at 1 April 2014 as previously stated	132	**132**
Provided during the year	70	**70**
Amortisation at 31 March 2015	202	**202**
Net book value		
NBV - Owned at 31 March 2015	334	**334**
NBV total at 31 March 2015	**334**	**334**

8.1 Property, plant and equipment 2015/16

	Land	Buildings excluding dwellings	Dwellings	Assets under Construction & POA	Plant & Machinery	Transport Equipment	Information Technology	Furniture & Fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2015 as previously stated	10,650	69,837	406	1,921	25,095	3,809	13,150	220	**125,088**
Additions - purchased (including donated)	0	2,140	0	13,567	2,479	97	2,287	0	**20,570**
Reclassifications	0	8,049	32	(8,186)	0	0	105	0	**0**
Disposals	0	0	0	0	(110)	(6)	(437)	(10)	**(563)**
Cost or valuation at 31 March 2016	**10,650**	**80,026**	**438**	**7,302**	**27,464**	**3,900**	**15,105**	**210**	**145,095**
Accumulated depreciation at 1 April 2015 as previously stated	0	0	0	0	16,062	1,057	4,732	210	22,061
Provided during the year	0	3,124	13	0	2,446	488	2,007	2	**8,080**
Disposals	0	0	0	0	(36)	(7)	(437)	(10)	**(490)**
Accumulated depreciation at 31 March 2016	**0**	**3,124**	**13**	**0**	**18,472**	**1,538**	**6,302**	**202**	**29,651**
Net book value									
NBV - Owned at 31 March 2016	10,650	64,308	393	7,302	8,525	2,362	8,803	8	102,351
NBV - PFI at 31 March 2016	0	10,814	0	0	0	0	0	0	10,814
NBV - Donated at 31 March 2016	0	1,780	32	0	467	0	0	0	**2,279**
NBV total at 31 March 2016	**10,650**	**76,902**	**425**	**7,302**	**8,992**	**2,362**	**8,803**	**8**	**115,444**

8.2 Property, plant and equipment 2014/15

	Land	Buildings excluding dwellings	Dwellings	Assets under Construction & POA	Plant & Machinery	Transport Equipment	Information Technology	Furniture & Fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2014 as previously stated	14,100	82,549	947	1,341	23,252	2,953	9,276	230	**134,648**
Additions - purchased (including donated)	0	1,709	0	3,630	3,015	862	3,972	0	**13,188**
Reclassifications	0	2,986	0	(3,050)	0	0	64	0	**0**
Revaluation Impact	(3,450)	(17,407)	(541)	0	0	0	0	0	**(21,398)**
Disposals	0	0	0	0	(1,172)	(6)	(162)	(10)	**(1,350)**
Cost or valuation at 31 March 2015	**10,650**	**69,837**	**406**	**1,921**	**25,095**	**3,809**	**13,150**	**220**	**125,088**
Accumulated depreciation at 1 April 2014 as previously stated	0	15,052	62	0	14,935	695	3,494	218	**34,456**
Provided during the year	0	4,031	34	0	2,295	368	1,400	2	**8,130**
Revaluations	0	(19,083)	(96)	0	(1)	0	0	0	**(19,180)**
Disposals	0	0	0	0	(1,167)	(6)	(162)	(10)	(1,345)
Accumulated depreciation at 31 March 2015	**0**	**0**	**0**	**0**	**16,062**	**1,057**	**4,732**	**210**	**22,061**
Net book value									
NBV - Purchased at 31 March 2015	10,650	57,526	406	1,921	8,664	2,752	8,418	10	**90,347**
NBV - PFI at 31 March 2015	0	10,539	0	0	0	0	0	0	**10,539**
NBV - Donated at 31 March 2015	0	1,772	0	0	369	0	0	0	2,141
NBV total at 31 March 2015	**10,650**	**69,837**	**406**	**1,921**	**9,033**	**2,752**	**8,418**	**10**	**103,027**

8.3 Economic life of property, plant and equipment

	Min Life Years	Max Life Years
Land	n/a	n/a
Buildings excluding dwellings	0	80
Dwellings	0	80
Assets under Construction & POA	n/a	n/a
Plant & Machinery	0	15
Transport Equipment	0	15
Information Technology	0	8
Furniture & Fittings	0	5
Intangible Software Licenses	0	8

9 Other Property Plant & Equipment Disclosures

The Trust received £291k of donated property, plant and equipment from the charitable funds associated with the hospital.

The Trust entered into a 10 year contract for the provision of medical records in February 2013. Due to the length of the contract, the expected life of the equipment in question and, on the basis that the equipment is solely used by this Trust, the Trust has recognised this equipment as property plant and equipment. The value of this equipment as at 31 March 16 was £1,834k.

The Trust's estate, encompassing land and buildings was revalued as at 31 March 2015. This valuation was completed by Gerald Eve LLP, professional valuers in accordance with the RICS Valuation - Professional Standards published by the Royal Institution of Chartered Surveyors. The Directors' opinion is that there are no property plant or equipment where the value is significantly different from the value included in the financial statements.

Land was valued using existing use value methodology at £10,650k using the concept of economic substitution of the service utility of the asset.

Given the specialised nature of the buildings the majority of the estate has been valued using depreciated replacement cost based on modern equivalent assets at a value of £72,182k.

There are various small assets which are temporarily idle, although not for sale, where the period for which the asset is idle is uncertain these have had their depreciation accelerated and are held on the Statement of Financial Position at values reflecting their short remaining economic lives.

10.1 Non-current assets for sale and assets in disposal groups

The Trust held no non-current assets for sale nor assets in disposal groups in 2014/15 or 2015/16.

10.2 Liabilities in disposal groups

The Trust held no liabilities in disposal groups in 2014/15 nor 2015/16.

11 Investments

	Parent		Group	
	31 March 2016 £000	31 March 2015 £000	31 March 2016 £000	31 March 2015 £000
NHS Charitable funds: Other investments				
Carrying value at 1 April 2015	0	0	**3,208**	3,369
Acquisitions in year - other	0	0	**375**	666
Fair value gains (taken to I&E)	0	0	**0**	251
Fair value losses (impairment) [taken to I&E]	0	0	**(164)**	(13)
Disposals	0	0	**(347)**	(1,065)
Carrying value at 31 March 2016	**0**	**0**	**3,072**	**3,208**

12 Associates & Jointly Controlled Operations

The NHS foundation trust is the corporate trustee to Luton & Dunstable Hospital Charitable Funds. The foundation trust has assessed its relationship to the charitable fund and determined it to be a subsidiary because the foundation trust is exposed to, or has rights to, variable returns and other benefits for itself, patients and staff from its involvement with the charitable fund and has the ability to affect those returns and other benefits through its power over the fund.

As the accounting policies applicable to both the Trust and the Charitable Funds are consistent no adjustment other than intra-group transactions has been required.

The Trust had no other associates nor jointly controlled operations in 2014/15 nor 2015/16.

13.1 Inventories

	31 March 2016 £000	31 March 2015 £000
Drugs	983	702
Consumables	2,227	1,813
TOTAL INVENTORIES	**3,210**	**2,515**

13.2 Inventories recognised in expenses

	2015/16 £000	2014/15 £000
Additions	44,301	40,739
Inventories recognised in expenses	(43,606)	(40,780)
MOVEMENT IN INVENTORIES	**695**	**(41)**

14.1 Trade receivables and other receivables

	Parent		Group	
	31 March 2016 £000	Restated 31 March 2015 £000	31 March 2016 £000	Restated 31 March 2015 £000
Current				
NHS Receivables	**6,754**	14,157	**6,754**	14,157
Other receivables with related charitable funds	**21**	43	**0**	0
Other receivable with related parties	**482**	417	**482**	417
Provision for impaired receivables	**(993)**	(1,085)	**(993)**	(1,085)
Prepayments	**3,202**	2,781	**3,202**	2,781
Prepayments - Lifecycle replacements	**44**	44	**44**	44
Accrued income	**6,775**	4,699	**6,775**	4,699
PDC dividend receivable	**23**	0	**23**	0
VAT receivable	**1,263**	953	**1,263**	953
Other receivables	**2,947**	2,879	**2,947**	2,879
NHS Charitable funds: Trade and other receivables	**0**	0	**6**	3
TOTAL CURRENT TRADE AND OTHER RECEIVABLES	**20,518**	**24,888**	**20,503**	**24,848**
Non-Current				
Prepayments	109	70	109	70
Prepayments - PFI related	394	438	394	438
Accrued income	989	695	989	695
TOTAL NON CURRENT TRADE AND OTHER RECEIVABLES	**1,492**	**1,203**	**1,492**	**1,203**

14.2 Provision for impairment of receivables

	31 March 2016 £000	31 March 2015 £000
At 1 April 2015	1,085	1,689
Increase in provision	67	82
Amounts utilised	(159)	(686)
At 31 March 2016	**993**	**1,085**

14.3 Analysis of impaired receivables

	31 March 2016 £000	31 March 2015 £000
Ageing of impaired receivables		
0 - 30 days	**60**	44
30-60 Days	**32**	26
60-90 days	**32**	30
90- 180 days	**120**	82
over 180 days	**749**	903
Total	**993**	**1,085**
Ageing of non-impaired receivables past their due date		
0 - 30 days	**1,977**	1,538
30-60 Days	**836**	1,228
60-90 days	**259**	4,406
90- 180 days	**2,304**	3,985
over 180 days	**3,390**	1,510
Total	**8,766**	**12,667**

The Trust has reviewed the not due and non impaired receivables and has satisfied itself that there is no evidence of impairment which have an impact on the estimated future cash flows of the assets.

Note 14.4 Finance lease receivables

During 2015/16 the Trust did not have any finance lease receivables.

Note 15 Other assets (Non Current)

	31 March 2016 £000	31 March 2015 £000
PFI Scheme - lifecycle costs	2,712	2,848
Total	**2,712**	**2,848**

16.1 Trade and other payables

	Parent		Group	
	31 March 2016 £000	31 March 2015 £000	31 March 2016 £000	31 March 2015 £000
Current				
Receipts in advance	**47**	0	**47**	0
NHS payables	**3,416**	2,242	**3,416**	2,242
Amounts due to other related parties - revenue	**2,109**	2,001	**2,109**	2,001
Trade payables - capital	**2,897**	1,435	**2,897**	1,435
Other trade payables	**3,035**	4,426	**3,035**	4,426
Social Security costs	**3,383**	3,344	**3,383**	3,344
Other payables	**682**	702	**682**	702
Accruals	**7,354**	10,299	**7,354**	10,299
PDC Dividend Payable	**0**	7	**0**	7
NHS Charitable funds: Trade and other payables	**0**	0	**147**	30
TOTAL CURRENT TRADE & OTHER PAYABLES	**22,923**	**24,456**	**23,070**	**24,486**
Non-Current				
Other trade payables - capital	0	0	**0**	0
TOTAL NON CURRENT TRADE & OTHER PAYABLES	**0**	**0**	**0**	**0**

NHS payables do not include any outstanding pension contributions due to NHS Pensions Agency as at 31 March 2016.

17 Other liabilities

	31 March 2016 £000	31 March 2015 £000
Current		
Deferred Income	**1,823**	1,851
TOTAL OTHER CURRENT LIABILITIES	**1,823**	**1,851**

There are no non current other liabilities in 2014/15 nor 2015/16.

18 Borrowings

	31 March 2016 £000	31 March 2015 £000
Current		
Capital loans from Department of Health	**198**	0
Other loans	**26**	0
Obligations under Private Finance Initiative contracts	**393**	185
TOTAL CURRENT BORROWINGS	**617**	**185**
Non-current		
Capital loans from Department of Health	**9,302**	0
Obligations under Private Finance Initiative contracts	**11,380**	11,777
TOTAL OTHER NON CURRENT LIABILITIES	**20,682**	**11,777**

19. Prudential Borrowing Limit

The prudential borrowing code requirements in section 41 of the NHS Act 2006 have been repealed with effect from 1 April 2014 by the Health and Social Care Act 2012. The financial statements disclosures that were provided previously are no longer required.

20. Finance lease obligations

The Trust had no finance lease obligations during 2015/16 other than the PFI scheme arrangement.

21.1 PFI obligations (on SoFP)

	31 March 2016 £000	31 March 2015 Restated £000
Gross PFI liabilities	**18,156**	19,082
of which liabilities are due		
- not later than one year;	**1,126**	925
- later than one year and not later than five years;	**5,335**	5,080
- later than five years.	**11,695**	13,077
Finance charges allocated to future periods	**(6,383)**	(7,120)
Net PFI liabilities	**11,773**	**11,962**
- not later than one year;	**393**	185
- later than one year and not later than five years;	**2,725**	2,335
- later than five years.	**8,655**	9,442

21.2 The Trust is committed to make the following payments for on-SoFP PFIs obligations during the next year in which the commitment expires:

	31 March 2016 Total £000	31 March 2015 Total £000
Within one year	**1,676**	1,632
2nd to 5th years (inclusive)	**6,704**	6,528
Later than 5 years	**14,246**	15,504
Total	**22,626**	**23,664**

The Trust incurred £825k expenditure in respect of the service charge under the PFI contract (£752k in 2014/15). This is shown within the Premises category in Note 3.1.

22 Provisions for liabilities and charges

Parent	Current		Non-current	
	31 March 2016 £000	31 March 2015 £000	31 March 2016 £000	31 March 2015 £000
Pensions relating to other staff	**64**	64	**650**	749
Other legal claims	**96**	516	**0**	0
Agenda for Change	**0**	981	**0**	0
Restructuring	**0**	0	**0**	0
Redundancy	**152**	180	**0**	0
Other	**96**	81	**0**	0
Total	**408**	**1,822**	**650**	**749**

Group	Current		Non-current	
	31 March 2016 £000	31 March 2015 £000	31 March 2016 £000	31 March 2015 £000
Pensions relating to other staff	**64**	64	**650**	749
Other legal claims	**96**	516	**0**	0
Agenda for Change	**0**	981	**0**	0
Restructuring	**0**	0	**0**	0
Redundancy	**152**	180	**0**	0
Other	**96**	81	**0**	0
NHS charitable fund provisions	**384**	244	**105**	205
Total	**792**	**2,066**	**755**	**954**

	Pensions - other staff £000	Other legal claims £000	Agenda for Change £000	Redundancy £000	Other £000	NHS charitable fund provisions £000	Total £000
At 1 April 2015 restated	**813**	**516**	**981**	**180**	**81**	**449**	**3,020**
Arising during the year	0	78	0	0	87	0	165
Utilised during the year	(64)	(66)	0	0	0	0	(130)
Reversed unused	(46)	(432)	(981)	(28)	(72)	0	(1,559)
Unwinding of discount	11	0	0	0	0	0	11
NHS charitable funds: movement in provisions	0	0	0	0	0	40	40
At 31 March 2016	**714**	**96**	**0**	**152**	**96**	**489**	**1,547**
Expected timing of cashflows:							
- not later than one year;	64	96	0	152	96	384	792
- later than one year and not later than five years;	254	0	0	0	0	105	359
- later than five years.	396	0	0	0	0	0	396
TOTAL	**714**	**96**	**0**	**152**	**96**	**489**	**1,547**

Provisions for legal claims represents the gross estimated liability from employer and public liability cases. These cases are managed by NHS Litigation Authority through the LTPS scheme, the amount of the provision recoverable from NHS Litigation Authority is included within debtors.

£114,813k is included in the provisions of the NHS Litigation Authority at 31/03/2016 in respect of clinical negligence liabilities of the Trust (31/03/2015 £72,043k).

Other provisions relate to various provisions for trading and employment contractual issues (all less than £1m).

23 Revaluation reserve

	Revaluation Reserve -property, plant and equipment £000	Total Revaluation Reserve* £000
Revaluation reserve at 1 April 2015	11,522	**11,522**
Revaluation Impact	0	**0**
Other Movements	0	**0**
Revaluation reserve at 31 March 2016	**11,522**	**11,522**
Revaluation reserve at 1 April 2014	13,740	**13,740**
Revaluation Impact	(2,218)	**(2,218)**
Other Movements	0	**0**
Revaluation reserve at 31 March 2015	**11,522**	**11,522**

* The Trust held no revaluation reserve in respect of intangible assets.

24 Charitable Funds Summary Statements

As per Note 12, below summarises the NHS Charity's accounts which have been consolidated within the Group's accounts in accordance with IAS 27.

	Subsidary	
	2015/16 £000	2014/15 £000
Statement of Financial Activities/ Comprehensive Income		
Incoming resources	**462**	592
Resources expended	**(1,071)**	(579)
Net resources expended	**(609)**	**13**
Incoming Resources: investment income	91	83
Fair value movements on investments	(165)	238
Net movement in funds	**(683)**	**334**

	31 March 2016 £000	31 March 2015 £000
Statement of Financial Position		
Non-current assets	3,072	3,208
Current assets	262	673
Current liabilities	(551)	(317)
Non-current liabilities	(105)	(205)
Net assets	**2,678**	**3,359**
Funds of the charity		
Endowment funds	1	1
Other Restricted income funds	788	790
Unrestricted income funds	1,889	2,568
Total Charitable Funds	**2,678**	**3,359**

25 Cash and cash equivalents

	Parent		Group	
	31 March 2016 £000	31 March 2015 £000	31 March 2016 £000	31 March 2015 £000
At 1 April	**11,655**	24,974	**12,325**	25,258
Prior period adjustment	**0**	0	**0**	0
At 1 April (restated)	**11,655**	24,974	**12,325**	25,258
Net change in year	**(2,509)**	(13,319)	**(2,922)**	(12,933)
At 31 March	9,146	11,655	9,403	12,325
Broken down into:				
Cash at commercial banks and in hand	**60**	142	**60**	142
NHS charitable funds: cash held at commercial bank	**0**	0	**257**	670
Cash with the Government Banking Service	**9,086**	11,513	**9,086**	11,513
Cash and cash equivalents as in SoFP	**9,146**	**11,655**	**9,403**	**12,325**
Cash and cash equivalents as in SoCF	**9,146**	**11,655**	**9,403**	**12,325**

The Trust held £330 cash at bank and in hand at 31/03/16 which relates to monies held by the Trust on behalf of patients.

26.1 Contractual Capital Commitments

The Trust had contractual capital commitments totalling £0.588m at 31 March 2016.

26.2 Events after the reporting period

There have been no events after the reporting period end requiring disclosure.

The Director of Finance authorised the financial statements for issue on 25 May 2016.

27. Contingent (Liabilities) / Assets

	31 March 2016 £000	31 March 2015 £000
Gross value of contingent liabilities	**46**	35
Net value of contingent liabilities	**46**	35
Net value of contingent assets	**0**	0

Contingent liabilities relate to claims that the NHS Litigation Authority is aware of and has requested that we disclose.

28 Related Party Transactions

The Luton & Dunstable Hospital NHS Foundation Trust is a body corporate established by order of the Secretary of State for Health.

During the year none of the Board Members or members of the key management staff or parties related to them has undertaken any material transactions with the NHS Foundation Trust.

All bodies deemed to be within the remit of the United Kingdom 'Whole of Government' are regarded as related parties. During the year the Trust has had significant transactions with the bodies disclosed in this note.

The Trust is the Corporate Trustee for the Charitable Funds, the transactions for which have been consolidated within these financial statements in accordance with IAS 27.

	Income 2015/16 £000	Expenditure 2015/16 £000	Income 2014/15 £000	Expenditure 2014/15 £000
NHS and DH				
Aylesbury Vale CCG	**2,745**	**0**	2,273	0
Bedfordshire CCG	**59,335**	**0**	57,387	0
Department of Health	**2,020**	**2,960**	0	2,786
Health Education England	**8,116**	**0**	8,316	9
Herts Valleys CCG	**19,271**	**0**	17,323	0
Luton CCG	**118,388**	**0**	114,295	139
NHS England: East Commissioning Hub[1]	**27,690**	**0**	25,994	0
NHS England: Central Midlands Local Office[2]	**8,944**	**0**	9,053	0
NHS Litigation Authority	**0**	**6,384**	0	6,562
Central Government				
HM Revenue and Customs	**0**	**11,787**	0	11,377
National Health Service Pension Scheme	**0**	**14,949**	0	13,846

[1] Formerly known as East Anglia Area Team

[2] Formerly known as Hertfordshire & the South Midlands Area Team

28 Related Party Transactions continued

Related Party Balances	Receivables 31 March 2016 £000	Payables 31 March 2016 £000	Receivables 31 March 2015 £000	Payables 31 March 2015 £000
NHS and DH				
Aylesbury Vale CCG	**232**	**0**	337	0
Bedfordshire CCG	**1,395**	**0**	5,163	0
Department of Health	**23**	**22**	0	60
Health Education England	**45**	**6**	202	0
Herts Valleys CCG	**2,225**	**0**	986	0
Luton CCG	**2,692**	**0**	8,049	20
NHS England: East Commissioning Hub[1]	**1,961**	**0**	0	44
NHS England: Central Midlands Local Office[2]	**0**	**762**	0	0
NHS Litigation Authority	**0**	**0**	0	0
Central Government				
HM Revenue and Customs	**1,263**	**3,383**	953	3,344
National Health Service Pension Scheme	**0**	**2,079**	0	1,991

[1] Formerly known as East Anglia Area Team

[2] Formerly known as Hertfordshire & the South Midlands Area Team

29.1 For PFI schemes deemed to be off-SoFP

The Trust ended the off SoFP PFI scheme relating to the provision of the electronic patient record system in 2011/12. There are no transactions within either 2014/15 or 2015/16 relating to an off-SoFP PFI scheme.

29.2 Further narrative on PFI schemes

The Trust had two capital schemes arranged under PFI arrangements, one of these ended in 2011/12.

1. St Mary's Wing scheme was completed in 2003 under a 27 year scheme with 14 years remaining. The operator is responsible for maintaining the building during this period and ownership reverts to the Trust at the end of the contract. There are no break clauses nor re-pricing dates (On-SoFP)

2. The contract for the electronic patient record scheme has now finished. This contract was for 10 years.

There were no new PFI schemes in the year and any future schemes are unlikely as they would be funded either through internally generated resources or external financing using the additional freedoms granted to Foundation Trusts.

30.1 Financial assets by category

	Parent		Group	
	Loans and receivables £000	Total £000	Loans and receivables £000	Total £000
Assets as per SoFP				
Trade and other receivables excluding non financial assets (at 31 March 2016)	20,239	**20,239**	20,219	**20,219**
Cash and cash equivalents (at bank and in hand (at 31 March 2016))	9,146	**9,146**	9,146	**9,146**
NHS Charitable funds: financial assets (at 31 March 2016)	0	**0**	262	**262**
Total at 31 March 2016	**29,385**	**29,385**	**29,627**	**29,627**
Trade and other receivables excluding non financial assets (at 31 March 2015)	25,006	**25,006**	23,327	**23,327**
Cash and cash equivalents (at bank and in hand (at 31 March 2015))	11,655	**11,655**	11,655	**11,655**
NHS Charitable funds: financial assets (at 31 March 2015)	0	**0**	673	**673**
Total at 31 March 2015	**36,661**	**36,661**	**35,655**	**35,655**

Financial Assets risk split by category	Market Risk	Credit Risk	Liquidity Risk
NHS receivables	Low	Low	Low
Accrued income	Low	Low	Medium
Other debtors	Low	Low	Medium
Cash at bank and in hand	Low	Medium	Low

Overall risk is low, as the Trust limits foreign currency transactions, thus limiting market risk.

The Trust has a robust, audited, debt management policy that mitigates against the debtor liquidity risk. The Trust mitigates the cash credit risk by investing only in line with the Monitor compliant Treasury Management Policy.

30.2 Financial liabilities by category

	Parent		Group	
	Other financial liabilities £000	Total £000	Other financial liabilities £000	Total £000
Liabilities as per SoFP				
Borrowings excluding finance lease and PFI liabilities (at 31 March 2016)	9,526	**9,526**	9,526	**9,526**
Obligations under PFI, LIFT and other service concession contracts (at 31 March 2016)	11,773	**11,773**	11,773	**11,773**
Trade and other payables excluding non financial liabilities (at 31 March 2016)	22,923	**22,923**	22,923	**22,923**
NHS Charitable funds: financial liabilities (at 31 March 2016)	0	**0**	167	**167**
Total at 31 March 2016	**44,222**	**44,222**	**44,389**	**44,389**
Obligations under Private Finance Initiative contracts (31 March 2015)	11,962	**11,962**	11,962	**11,962**
Trade and other payables excluding non financial liabilities (restated 31 March 2015)	21,105	**21,105**	21,105	**21,105**
NHS Charitable funds: financial liabilities (restated 31 March 2015)	0	**0**	73	**73**
Total at 31 March 2015 (Restated)	**33,067**	**33,067**	**33,140**	**33,140**

Financial Liabilities risk split by category	Market Risk	Credit Risk	Liquidity Risk
NHS creditors	Low	Low	Low
Other creditors	Low	Low	Low
Accruals	Low	Low	Low
Capital creditors	Low	Low	Low
Provisions under contract	Low	Low	Low

Overall risk is low, as the Trust limits foreign currency transactions, thus limiting market risk.

All major contractors are credit checked prior to the awarding of the contract, thus limiting credit risk.

The Trust mitigates the liquidity risk via 12 month forward cash planning.

30.3 Maturity of Financial Liabilities

	31 March 2016 £000	31 March 2015 Restated £000
In one year or less	23,392	21,364
In more than one year but not more than two years	1,145	396
In more than two years but not more than five years	3,549	1,938
In more than five years	16,303	9,442
Total	**44,389**	**33,140**

30.4 Fair values of financial assets at 31 March 2016

The fair value of the Trust's financial assets were the same as the book value as at 31 March 2016 (and 31 March 2015).

Note 30.5 Fair values of financial liabilities at 31 March 2016

	Parent		Group	
	Book Value	Fair value	Book Value	Fair value
	£000	£000	£000	£000
Non current trade and other payables excluding non financial liabilities	0	0	0	0
Provisions under contract	0	0	0	0
PFI Scheme Borrowing	20,682	20,682	9,526	9,526
NHS Charitable funds: non-current financial liabilities	0	0	0	0
Total	**20,682**	**20,682**	**9,526**	**9,526**

31.1 On-Statement of Financial Position pension schemes.

The Trust has no on Statement of Financial Position Pension Scheme transactions.

31.2 Off-Statement of Financial Position pension schemes.

NHS Pension Scheme
See Note 1.3 for details of the accounting treatment of the NHS Pension Scheme.

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

a) Accounting valuation
A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and are accepted as providing suitably robust figures for financial reporting purposes. The valuation of scheme liability as at 31 March 2016, is based on valuation data as 31 March 2015, updated to 31 March 2016 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the scheme actuary report, which forms part of the annual NHS Pension Scheme (England and Wales) Pension Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation
The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account their recent demographic experience), and to recommend contribution rates payable by employees and employers.
The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2012.
The Scheme Regulations allow for the level of contribution rates to be changed by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and appropriate employee and employer representatives as deemed appropriate.

c) Scheme provisions
The NHS Pension Scheme provided defined benefits, which are summarised below. This list is an illustrative guide only, and is not intended to detail all the benefits provided by the Scheme or the specific conditions that must be met before these benefits can be obtained:
The Scheme is a "final salary" scheme. Annual pensions are normally based on 1/80th for the 1995 section and of the best of the last three years pensionable pay for each year of service, and 1/60th for the 2008 section of reckonable pay per year of membership. Members who are practitioners as defined by the Scheme Regulations have their annual pensions based upon total pensionable earnings over the relevant pensionable service.
With effect from 1 April 2008 members can choose to give up some of their annual pension for an additional tax free lump sum, up to a maximum amount permitted under HMRC rules. This new provision is known as "pension commutation".

Annual increases are applied to pension payments at rates defined by the Pensions (Increase) Act 1971, and are based on changes in retail prices in the twelve months ending 30 September in the previous calendar year. From 2011-12 the Consumer Price Index (CPI) has been used and replaced the Retail Prices Index (RPI).
Early payment of a pension, with enhancement, is available to members of the scheme who are permanently incapable of fulfilling their duties effectively through illness or infirmity. A death gratuity of twice final year's pensionable pay for death in service, and five times their annual pension for death after retirement is payable.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to the employer.
Members can purchase additional service in the NHS Scheme and contribute to money purchase AVC's run by the Scheme's approved providers or by other Free Standing Additional Voluntary Contributions (FSAVC) providers.

National Employment Savings Trust (NEST)
The Trust offers employees an alternative pension scheme, NEST. This is a defined contribution, off statement of financial position scheme and the number of employees opting in and the value of contributions have been negligible (£5k employers contribution costs in year.)

32 Losses and Special Payments

	2015/16 Total number of cases Number	2015/16 Total value of cases £000's	2014/15 Total number of cases Number	2014/15 Total value of cases £000's
LOSSES:				
1.a. Losses of cash due to theft, fraud etc.	0	0	3	1
1. c. other causes	0	0	9	1
2. Fruitless payments and constructive losses	0	0	1	73
3.a. Bad debts and claims abandoned in relation to private patients	13	2	7	1
3.b. Bad debts and claims abandoned in relation to overseas visitors	39	86	211	537
3.c. Bad debts and claims abandoned in relation to other	48	67	118	73
TOTAL LOSSES	**100**	**155**	**349**	**686**
SPECIAL PAYMENTS:				
5. Compensation under legal obligation	1	0	1	1
7.a. Ex gratia payments in respect of loss of personal effects	16	4	17	8
7.b. Ex gratia payments in respect of clinical negligence with advice	0	0	2	0
7.c. personal injury with advice	6	4	2	3
7.d. Ex gratia payments in respect of other negligence and injury	9	1	3	1
TOTAL SPECIAL PAYMENTS	**32**	**9**	**25**	**13**
TOTAL LOSSES AND SPECIAL PAYMENTS	**132**	**164**	**374**	**699**

There were no compensation payments received.

33 Discontinued operations

There were no discontinued operations in 2015/16.

34 Corporation Tax

Corporation Tax is not due as the Trust is below the de minimis threshold as per the HMRC 'Guidance on the Tax Treatment of Non-core Healthcare Commercial Activities of NHS Foundation Trusts'.

35 Accounting standards that have been issued but have not yet been adopted

The following standards and interpretations have been adopted or amended by the European Union but are not required to be followed until 2016/17, at the earliest. None of them are expected to impact upon the Trust's financial statements.

- FRS 11 Acquisition of an Interest in a Joint Operation
- IAS 16 and IAS 38 Depreciation and Amortisation
- IAS 16 and IAS 41 Bearer Plants
- IAS 27 equity method in separate financial statements
- IFRS 10 and IAS 28 sale or contribution of assets
- IFRS 10 and IAS 28 investment entities applying the consolidation exception
- IAS 1 disclosure initiative
- IFRS 15 Revenue from contracts with customers
- Annual improvements to IFRS: 2012-15 cycle
- IFRS 9 Financial Instruments

Note 36 Other Financial Assets and Other Financial Liabilities

The Trust did not hold any 'Other Financial Assets' nor 'Other Financial Liabilities' during 2014/15 nor 2015/16.

37 Key Areas of Judgement & Estimation Uncertainty

The following have been identified as key areas of judgement and estimation uncertainty:-

- review of operating leases to determine whether the significant risks and rewards of ownership of the leased assets have transferred. To mitigate the risk of incorrect conclusions an external advisor's opinion was obtained.
- allocation of lifes to acquired plant and equipment (excluding buildings for which a valuer's opinion is obtained) to calculate the depreciation charge. This is estimated based on the lives of similar assets and knowledge of the procurer.
- income generated from partially completed spells and non contract income. These are estimated assuming that patterns of provision of service are consistent from year to year.
- accrued expenditure for annual leave is estimated byapplying NHS employment contracts' terms and conditions and Trust policy to the average annual leave balance for a sample of departments.

38 Segmented Operations

The Trust operates in one segment, that of the provision of healthcare, as reported to the Chief Operating Decision Maker, the Board.

Note 39 Foundation Trust Income Statement and Statement of Comprehensive Income

In accordance with Section 408 of the Companies Act 2006, the Trust is exempt from the requirement to present its own income statement and statement of comprehensive income. The trust's surplus for the period was £53k (2014/15: £66k). The trust's total comprehensive income for the period was £53k (2014/15 comprehensive expense: £2,152k).

Appendix 1 Quality Account

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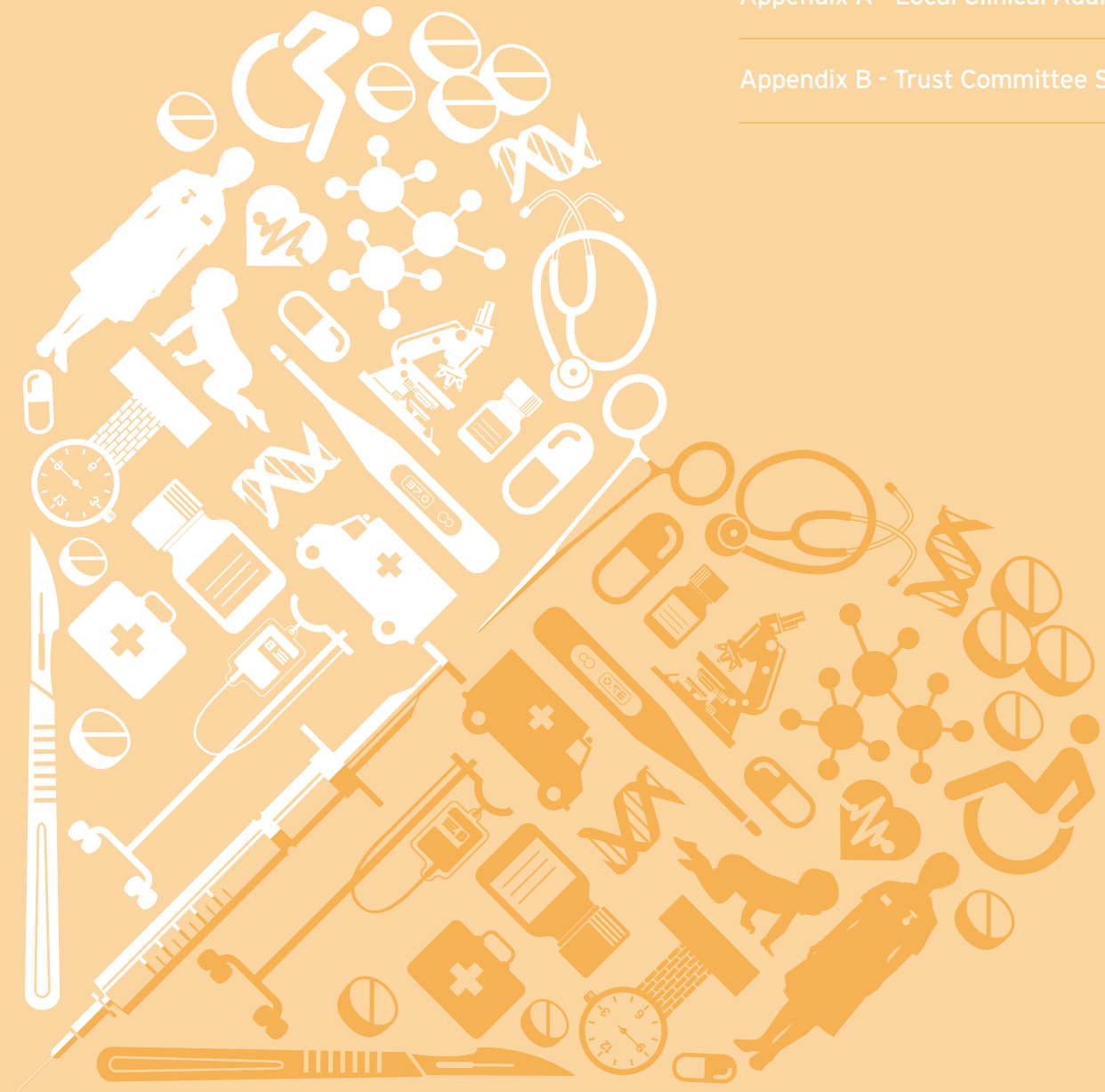


What is a Quality Account?

All providers of NHS services in England have a statutory duty to produce an annual Quality Account. This is a report that informs the public about the quality of the services that we deliver. They are published annually and are available to the public.
Quality Accounts aim to increase public accountability and drive quality improvement. They do this by requiring organisations to review their performance over the previous year, publish their performance and identify areas for improvement. Quality accounts will also inform you about how an organisation will make those improvements and how they will be measured.
A review of our quality of services for 2015/16 is included in this account alongside our priorities and goals for quality improvement in 2016/17 and how we intend to achieve them. This report summarises how we did against the quality priorities and goals that we set in 2015/16.

How is the 'quality' of the services provided defined?

We have measured the quality of the services we provide by looking at:

- Patient safety
- The effectiveness of treatments that patients receive
- How patients experience the care they receive

About our Quality Account

This report is divided into six sections. The first section contains a statement on quality from the Chief Executive and sets out our corporate objectives for 2016/17.

The second section looks at our performance in 2015/16 against the priorities that we set for patient safety, clinical effectiveness and patient experience.

The third section sets out our quality priorities and goals for 2016/17 for the same categories and explains how we intend to meet them and how we will monitor and report our progress.

The fourth section includes statements related to the quality of services that we have provided and includes Care Quality Commission registration information, data quality, information about clinical audits that we have undertaken and our research work.

The fifth section is a review of our quality performance and includes performance against national priorities and local indicators. It also provides examples of how we have improved services for patients.

The sixth section of the report includes a statement of Directors' responsibility in respect of the quality report.

The seventh section contains comments from our external stakeholders.

Some of the information in the Quality Account is mandatory; however most is decided by our staff and Foundation Trust Governors.

About Our Trust

The Luton and Dunstable University Hospital NHS Foundation Trust is a medium size general hospital with approximately 660 inpatient beds. The hospital provides a comprehensive range of general medical and surgical services, including Emergency Department (ED) and maternity services for people in Luton, Bedfordshire, Hertfordshire and parts of Buckinghamshire. Last year we provided healthcare services for over 90,000 admitted patients, nearly 400,000 outpatients and Emergency Department attendees and we delivered over 5,300 babies.

We serve a diverse population most of whom are the 210,000 people in Luton (Luton Annual Public Health Report 2013/14). Luton is an ethnically diverse town, with approximately 45% of the population from non-white British communities (Luton Borough Profile 2011 census data). Within this group there are significant Pakistani, Bangladeshi, Indian and African Caribbean communities. We celebrate the diversity of our population and are committed to ensuring that issues of equality and diversity have a high profile. There are particular healthcare challenges in an area with high levels of ethnicity. The 2010/11 Luton Annual Public Health reports states that in many cases, Black and Minority Ethnic (BME) communities have poorer health outcomes when compared to the overall population and these are linked to infant mortality, access to services due to awareness, language and cultural barriers, early onset dementia and diabetes.

The L&D has developed a range of specialist services including cancer, obesity, neurophysiology and oral maxillofacial (jaw) surgery. We have the responsibility for treating the most premature and critically ill newborn babies across the whole of Bedfordshire and Hertfordshire in our tertiary level Neonatal Intensive Care Unit (NICU). We also have one of the country's largest breast screening centres.

All inpatient services and most outpatient services are provided on the Luton and Dunstable Hospital site. The Trust provides community musculo-skeletal services (MSK) at three locations across the catchment area, including our new Orthopaedic Centre situated further along Dunstable Road and chronic obstructive pulmonary disease (COPD) and Diabetes services for South Bedfordshire.

The Trust has a strong and robust clinical management culture; all clinical services are managed by Clinical Chairs, Divisional Directors, supported by Clinical Directors, General Managers and Senior Nurses.

Division	Specialties	
Medicine	Emergency Department Acute Medicine Ambulatory Care Elderly Medicine Limb Fitting Stroke Service General Medicine Respiratory Medicine Diabetes and Endocrinology Gastroenterology	Cardiology Dermatology Heptology Neurology Neurophysiology Orthotics Genito Urinary Medicine Rheumatology Obesity
Surgery	General Surgery – Colorectal – Upper Gastrointestinal – Vascular – Bariatric Surgery Urology Paediatric Surgery Trauma & Orthopaedic Hospital at home Critical Care	Plastic Surgery ENT Cancer Services Medical Oncology Ophthalmology Oral & Maxillofacial Surgery Anaesthetics Pain Management Orthodontics Audiology
Women and Children's	Obstetrics Community Midwifery Early Pregnancy General Gynaecology Gynae-oncology	Paediatrics Fertility Neonatal Intensive Care Unit Uro-gynaecology Ambulatory Gynaecology

Division	Specialties	
Diagnostics, Therapeutics & Outpatients	Pathology Services - Blood Sciences - Cellular Pathology - Microbiology - - Phlebotomy Haematology Care Pharmacy Physiotherapy and Occupational Therapy	Imaging Musculoskeletal Services Dietetics Speech & Language Therapy Clinical Psychology Outpatients Breast Screening

During 2015/16 Divisional Directors, General Managers and Executive Directors met in the Executive Board.

In September 2015, we implemented new governance structures in the Division of Medicine and the Division of Surgery. Clinical Chairs for each division were appointed and monthly Executive Meetings established with each of the Clinical Divisions to increase clinical accountability at specialty level.

Other Executive meetings are dedicated to the Clinical Operational Board that reviews the clinical performance of the Trust and Re-Engineering programmes that focuses on the quality improvement programmes and efficiency.

1. A Statement on Quality from the Chief Executive

Part 1

As discussed in previous years, improving clinical outcome, patient safety and patient experience underpins the core values of L&D. This can be seen by reading our corporate objectives and understanding the progress that we are making year on year delivering sustained improvement.

During the year, we have continued to focus on quality improvement initiatives. We have maintained key work programmes such as the Mortality and Complaints Boards but have also increased leadership engagement through the introduction of a Transforming Quality Leadership 'Buddy' System.

As in previous years we consistently delivered against national and local quality and performance targets. We continued to be one of the best performing hospitals in the country for the waiting time targets in A&E and we achieved the 18 week performance. We also maintained a low number of C Diff with 11 cases.

Our quality priorities set out for 2015/16 have been embedded into our systems and processes and we made considerable progress. We

- Achieved 90% compliance with the Acute Kidney Injury (AKI) Bundle for those patients with stage 3 AKI and 90% of all AKI patients being discharged with full information.
- Made progress with both Clinical Commissioning Groups (CCGs) towards the provision of Integrated Care moving towards Needs Based Care.
- Maintained good performance in the falls resulting in severe harm.
- Achieved a further 40% reduction in hospital acquired grade three and four pressure ulcers.
- Maintained a low rate of cardiac arrests across the Trust.
- Implemented an electronic Prescribing and Medicines Administration System to reduce the risk of prescribing and administration errors.
- Achieved an improving outpatient experience with a reduction in short notice appointments rescheduled and a reduction in patients who do not attend their appointments.

We have also continued with the plans to further strengthen the governance arrangements within the clinical divisions and for raising patient safety concerns. We ensured that a programme of staff engagement was initiated to be able to communicate important information to staff, but to also engage with them about quality and patient safety priorities. Over 70% of staff attended these events.

This Quality Account focuses on how we will deliver and maintain our progress against our key quality practices in the coming year.

Pauline Philip
Chief Executive
25th May 2016

Corporate Objectives 2016/17

In 2014 -16 the Trust's Strategic Direction was underpinned by seven corporate objectives detailed in the Operational Plan. These objectives have been reviewed and objective 5 has been changed to reflect the changes to the strategic environment in relation to the Sustainability and Transformation Plans (STP).

1. Deliver Excellent Clinical Outcomes

- Year on year reduction in HSMR in all diagnostic categories

2. Improve Patient Safety

- Year on year reduction in clinical error resulting in harm
- Year on year reduction in HAI

3. Improve Patient Experience

- Year on year improvement in patient experience demonstrated through hospital and national patient surveys, leading to upper quartile performance

4. Deliver National Quality & Performance Targets

- Deliver sustained performance with all CQC outcome measures
- Deliver nationally mandated waiting times & other indicators

5. Implement our New Strategic Plan

- Deliver new service models in line with the emerging STP.
  - Emergency Hospital
  - Women & Children's Hospital
  - Elective Centre
  - Academic Unit
- Implementation of preferred option for the re-development of the site in line with the emerging STP.

6. Secure and Develop a Workforce to meet the needs of our Patients

- Develop and monitor the delivery of a comprehensive recruitment programme for all staff groups. The programme will incorporate a work plan focussing on retention.
- Ensure a culture where all staff understand the vision of the organisation and a highly motivated to deliver the best possible clinical outcomes.
- Deliver excellent in teaching a research as a University Hospital. Ensure that all staff have access to appropriate education and facilities to maintain their competence.

7. Optimise our Financial Plan

- Deliver our financial plan with particular focus on the implementation of re-engineering programmes

2. Report on Priorities for Improvement in 2015/16

Part 2

Last year we identified three quality priorities. This section describes what we did and what we achieved as a consequence. All of these priorities continue to be relevant and will be further developed during this current year.

We had key priorities each for patient safety, patient experience and clinical outcome. Our remaining priorities are detailed in the annual plan.

Priority 1: Clinical Outcomes

Key Clinical Outcome Priority 1

Implement a process for identifying patients with acute kidney injury (AKI) illness severity and reporting thorough the discharge summaries

Why was this a priority?

AKI is a sudden reduction in kidney function. In England over half a million people sustain AKI every year, and the condition affecting 5-15% of all hospital admissions As well as being common, AKI is harmful and often preventable, thus representing a major patient safety challenge for health care. It is a major factor in increasing patients' length of stay and can contribute to significantly increased mortality. AKI can also be viewed as an index condition for assessing the quality of the totality of care for all people with acute illness. There is evidence that care processes can be improved to provide better outcomes. Earlier recognition of illness severity and earlier senior clinical involvement in the care of unwell patients is therefore key to improving the safety, effectiveness and experience of care for patients admitted to hospital as an emergency. This was a key priority for the Trust last year where we focused on implementing a Trust- wide electronic system to improve detection and development of an AKI management care bundle. Building on this work, there are two key priorities for this year. These will focus on improved AKI diagnosis and treatment in hospital, and the provision of a plan of care to monitor kidney function after discharge.

What did we do?

The two key priorities for this year's AKI improvement project were to support early recognition and effective management for patients with AKI and also to provide a plan of care at discharge.

Objective 1. To support early recognition and effective management of patients presenting as emergencies admissions with AKI.

In order to support early recognition and effective management, the Trust has continued to use the AKI alerting system established last year in the electronic investigation results reporting system. The alerting system highlights when a patient has an abnormal creatinine, the indicator used to identify AKI. The reports also provide an indicator of the severity of the acute kidney injury, and provides clear guidance on the steps to take to support effective management for a patient with AKI.

The Trust has reinforced the importance of providing training and education in AKI, by making it mandatory for all junior doctors to complete the programme in induction. The programme provides education in recognition and effective management of AKI. Training has also been provided to nurses in EAU, in acute management of patients with AKI. In addition training has been provided to the multi-disciplinary team at specific training sessions and at clinical governance meetings.

Objective 2. Provide a plan of care to monitor kidney function after discharge.

A process has been set up to provide patients who were diagnosed with stage 2 or stage 3 AKI during their in-patient stay, with a discharge summary that includes the following key items of information:

- Information regarding medication changes during the inpatient stay, especially nephrotoxic medication that might be harmful to patient's with deteriorating renal function. This information helps inform the patient's GP to plan medication carefully as the patient's kidney function is restored.
- Stage of AKI (a key aspect of AKI diagnosis with stage 3 being the most severe.
- Recommendations regarding the type of blood tests required on discharge for monitoring renal function post discharge.
- Frequency of blood tests required on discharge for monitoring (a key aspect of post discharge care).

How did we perform?

More than 90% of our junior doctors have completed the AKI eLearning training module, increasing the likelihood that patients with AKI will get the treatment necessary to maximise their recovery.

An AKI discharge template has been developed and the discharge letter is started when a patient develops stage 2 or 3 AKI. The template prompts the doctor writing the discharge letter to complete the necessary information regarding medication changes and recommended.

blood tests for monitoring renal function. In Quarter 4, compliance at the time of reporting has been excellent with more than 90% of AKI patient discharged with full information.

This priority was a national CQUIN and the Trust achieved the requirements.

Key Clinical Outcome Priority 2

Implement a new model of integrated care for older people

Why was this a priority?

'Integrated care' is a term that reflects a new way of working to improve patient experience and achieves greater efficiency and value from health delivery systems. The aim is to address fragmentation in patient services, and enable better coordinated and more continuous care, most frequently for an ageing population with increasing incidence of chronic disease.

During 2014/15, the Trust worked with stakeholders within the Luton and Central Bedfordshire health economy to progress a new integrated model of care for the local elderly population. Progress has been made in the past year in designing a new model of care that will ensure patients receive care that is coordinated and delivered in the most appropriate setting. The work has focused on identifying the population group, gaining consent from patients, finding technical solutions to the sharing of information, reorganising Primary Care into "Clusters" of GP practices and aligning elderly care consultants to the Clusters. We are now ready to introduce new pathways of care to test the model and implement it across Luton and South Bedfordshire.

What did we do?

During 2015/2016 the Integrated Care for Older People work focused on delivering two components; one was delivered externally, in collaboration with the Better Together Board. It focused on the alignment of health and social care services around the GP Clusters and the setting up of multi-disciplinary teams (MDT) to support the management of complex patients in order to avoid unnecessary admissions to hospital. The second component was delivered internally and explored the possibility of care being organised in a way that supported the Cluster population model and provided continuity of care for patients from one admission to the next.

The pilot was led by a Geriatrician working across Primary Care with the Cluster 1 GPs in Luton. The proposal was for the Geriatrician to directly manage the care of patients from Cluster 1 requiring specialist elderly medicine. It also involved the Geriatrician attending Cluster 1 practice MDT meetings, the setting up of "hot" clinics to see patients on the same day or within 24hrs of referral and seeing patients in their own home when this was appropriate.

The Trust remains committed to the alignment of our elderly care consultants to the local GP clusters. Job plans for new elderly care consultants have been agreed and is based on work across primary and secondary care and the provision of "hot clinics". The ward reconfiguration has begun that will support Needs Based Care with our elderly care wards already reduced to two and the introduction of a cardiology ward next month.

Work has begun with the wider consultant body to agree the model of care on all specialty wards that will provide continuity of care and the new model of acute medicine. The clinical director for Elderly Medicine and the General Manager for Medicine are currently exploring the most appropriate Frail Elderly Model that will interface with Medical Short Stay and the Complex Needs Wards.

How did we perform?

The Cluster alignment has been completed in Luton and the MDTs are in the process of being standardised. The Cluster 1 Pilot was able to demonstrate that a new model of care that will provide continuity of care for patients and allow more collaborative work with Primary Care is possible. There were a number of qualitative benefits for patients and GPs identified through the pilot. This was especially the case with patients living in Care Homes and immobile patients in their own home. GPs benefited from the easy access to a specialist opinion and the pilot was also able to identify changes that need to be put in place within the current medical model to enable the full roll out of integrated care. A programme has been launched to introduce a Needs Based Care approach which will be the vehicle used to introduce integrated care to all medical specialties.

We initiated a review of our delayed transfers of care and medically fit for discharge patients that will continue in 2016/17. Both continue to be a cause for concern with at least two wards worth of these patient in our beds at any given time making reductions in length of stay a challenge given we have little or no control over access to external health and social care capacity. It is credit to the Integrated Discharge Team and the focus on length of stay that the Trust has been able meet the demand it faced over the winter period. The Trust will continue to look at innovative ways of reducing length of stay.

Key Clinical Outcome Priority 3

Implement processes for screening patients for sepsis and ensuring that intravenous antibiotics are initiated within 1 hour of presentation for those patients who have suspected severe sepsis, Red Flag Sepsis or septic shock

Why is this a priority?

Sepsis is a common and potentially life threatening condition where the body's immune system goes into overdrive in response to infection. Sepsis is recognised as a significant cause of mortality and morbidity in the NHS, with around 37,000 deaths attributed to sepsis annually. Of these, some estimates suggest 12,500 deaths could have been prevented, thought to be due in part to problems in achieving consistent recognition and rapid treatment of sepsis. Early detection and effective management of patients presenting with sepsis as an emergency will reduce morbidity and mortality amongst these patients.

What did we do?

The sepsis quality priority for 2015-16 has been to focus on patients of all ages presenting with sepsis in our Emergency Department. There have been two main objectives:

- Timely recognition of severe sepsis and septic shock
- The provision of antibiotics within an hour to those patients presenting as severely septic, or in septic shock

To support these two key objectives sepsis screening tools for both adults and paediatric patients have been revised. The revised tools have been implemented alongside training and education for all staff in all the clinical areas accepting patients as emergencies.

Pathways for septic patients arriving at the hospital have been revised to ensure delays are minimised and patients are managed effectively so that those patients with either severe sepsis or septic shock get their antibiotics within the hour.

How did we perform?

Audit has shown that compliance with sepsis screening is now above 90% and 71% of patients presenting with severe sepsis or septic shock now receive antibiotics within one hour.

This priority was a national CQUIN and the Trust achieved the requirements.

Priority 2: Patient Safety

Ensure that we have the appropriate level of clinical expertise available to deliver consistent inpatient care irrespective of the day of the week

Why was this a priority?

The Trust believes that patients should be able to access urgent and emergency care services, and their supporting diagnostic services, seven days a week. There is considerable evidence linking poorer outcomes for patients admitted to hospital as an emergency at the weekend, and this variation is seen in mortality rates, patient experience, length of hospital stay and re-admission rates. Delivering this ambition in a clinically and financially sustainable way requires transformational change and collaboration between providers of services across the health and social care system.

In line with the Keogh Report standards, the Trust began an implementation programme during 2014/15 and successfully implemented the recommendation in relation to consultant reviews being undertaken within 14 hours of arrival.

A whole system steering group has been established to ensure that efforts to increase service availability seven days a week work in partnership. The National Self-Assessment tool kit has been completed and five areas for focus selected for this financial year. The priorities align with the ten Keogh clinical standards and will need to be delivered across all organisations.

What did we do?

Four clinical standards out of the ten have been prioritised. The four standards are; Time to first consultant review; Availability of diagnostics; Consultant-led interventions; and Ongoing consultant review. These are considered the most likely to have the greatest impact on reducing variation in mortality risk. In August 2015 the Trust took part in a baseline audit to understand the extent to which the Trust was delivering these four priority clinical standards.

The Trust has processes in place to monitor time to first consultant review and work is on-going with junior medical staff to ensure accurate documentation.

Imaging has expanded service provision across a number of modalities, with MRI operating hours increased further during the course of 15/16 to meet demand and ensure patients are appointed within 6 weeks. Weekend services are already established in all main imaging modalities, but additional lists have been initiated.

Ultrasound has plans to expand direct access and create capacity to meet the 2 week wait demand and support cancer pathways. Breast Screening has also facilitated growth in evening clinics to meet Breast Symptomatic demand and achieve cancer performance targets.

Pathology introduced a substantive shift system to improve out of hours services and 7 day service provision, with increased investment in staff and training competencies to meet new regulatory standards, and Outpatients have also introduced a substantively staffed service on Wednesday and Thursday evenings and on Saturdays, improving access, expanding patient choice and enabling specialty service growth with the commencement of new consultant posts within the Trust.

How did we perform?

7 day working is embedded in a number of services within the Trust and working patterns and rotas are already designed with this in mind. Significant progress has been made in imaging and work is planned for delivering the on-going consultant review standard. The following is in place:

1. Senior clinical presence continues to midnight 7 day a week

2. CT, MRI, plain film and ultrasound are 7 day services, with a level of inpatient service consistent with Monday to Friday services. Consultant radiologists are on site on a Saturday and Sunday morning, and are on call throughout the remainder of the weekend and out of hours, available for reporting of urgent in-patient scanning from home. The department is working towards Keogh standards with regards request to scan and request to report TAT. In-patient Pathology services are available 24/7, 7 days a week. At weekends and out of hours, specialist clinical advice is available on an on-call basis.

3. Mental Health provision in A&E is much improved with ELFT. There is dedicated provision and we are monitoring mental health readmissions as part of the CQUIN

4. On-going work is in place throughout the community to improve discharges. Discharges on a Saturday remain high.

5. Patient experience continues to be monitored and this is reported through the quarterly patient experience report.

The Trust has participated in the national 7 Day Services progress survey in April 2016 with results expected to be made available by the end of May 2016.

Key Patient Safety Priority 2

Ongoing development of the Safety Thermometer, improving performance year on year

Why was this a priority?

The NHS Safety Thermometer continues to provide nurses with a point of care survey tool to check fundamental levels of care, identify where things go wrong and take prompt action. It is used by frontline healthcare workers to measure and track the proportion of patients in their care with pressure ulcers, urinary tract infections, VTE and who have had a fall and sustained harm

We will continue in our use of the monthly Safety Thermometer audits during 2016/17 which will provide on-going measurement of harm from pressure ulcers, falls, urinary infection in patients with catheters and treatment for VTE.

What did we do?

During 15/16 we continued to participate in the point of care survey measuring any new harms patients incurred during their inpatient stay. Ward staff were encouraged to review their results each month and discuss their findings. Any new harms which patients incurred was subject to a root cause analysis.

In support of the monthly prevalence we also monitored the incidence figures ensuring that appropriate interventions are made, led by the respective Clinical Nurse Specialists.

How did we perform?

During 2015/16 we consistently achieved new harm free care score of over 98%.

New Harm Free: patients with New-Harm Free Care

	Mar15	Apr15	May15	Jun15	Jul15	Aug15	Sep15	Oct15	Nov15	Dec15	Jan16	Feb16	Mar16
New Harm Free	99.67	98.03	98.62	97.94	99	98.68	98.72	98.54	99.09	98.19	98.36	98.96	99.54
One New Harm	0.33	1.97	1.23	2.06	1	1.32	1.28	1.46	0.91	1.81	1.64	1.04	0.46
Two New Harms	0	0	0.15	0	0	0	0	0	0	0	0	0	0
Three New Harms	0	0	0	0	0	0	0	0	0	0	0	0	0
Four New Harms	0	0	0	0	0	0	0	0	0	0	0	0	0
Patients	612	609	650	582	600	607	623	616	657	663	611	670	649

- **Pressure Ulcers** - The Trust continue to reduce the overall incidence of category two and three hospital acquired avoidable pressure ulcers (reduced by a further 40% on last year's rate). This was achieved through supporting and educating nursing staff across the organisation on the early identification, prompt validation and subsequent management of skin breakdown and continually learning through the Root Cause Analysis (RCA) process. The Tissue Viability Nurse has actively engaged in the countywide pressure ulcer group to share learning to enable a further reduction of both community and hospital acquired pressure ulcers, this has also included the development of a system wide Wound Care Formulary.

- **Falls -** During 2015/16 the 1000 bed days data has remained similar: 4.24 in 2014/15 and 4.32 in 2015/16. There were 29 falls with harm in 2014/15 and 20 in 2015/16. Whilst some falls are avoidable, reducing falls in an ageing and more frail population with complex health needs, is very challenging. We have maintained our current prevalence level focusing our attention on our management of the frail elderly and working with the dementia nurse specialist on at risk dementia patients, looking at how we manage the patients in the clinical setting using individual risk assessment and cohort nursing/specialling "at risk" patients as appropriate.

- **Catheter Related Urinary Tract Infections -** The use of urinary catheters has remained relatively static during the year at 18%, peaks and troughs in usage determined by the acuity and number of in patients at the time of the prevalence study (0.4%) The Continence Nurse Specialist works with wards with high usage and ensures that a robust process is in place to evaluating the need for catheters on a daily basis. There has been no catheter related urinary tract infection during the last two months of the year. The Trust is slightly above the national average of 15% and this is due to the increasing acuity of patients and the need to monitor fluid balances.

- **VTE -** Hospital acquired Venous Thromboembolism (VTE) is an important patient safety issue resulting in significant mortality, morbidity and healthcare resource expenditure. During the year the VTE compliance has been above 95%.

Key Patient Safety Priority 3

Improve the management of the deteriorating patient

Why was this a priority?

The recognition of acute illness is often delayed and its subsequent management can therefore be inappropriate. This is because clinicians' may fail to monitor, document or act on physiological abnormalities in a timely way, commonly described as "Failure to Rescue". This in turn leads to further deterioration in the patient's clinical condition and potential death. Although the Trust's average cardiac arrest rate continues to be lower than the national average, analysis of the cardiac arrests for 2014 -15 has highlighted areas for improvement. This includes earlier identification of the deteriorating patient by timely and appropriate observations and prompt medical action to prevent further deterioration. This was a key priority for the Trust last year where we established a deteriorating patient steering group and an innovative training programme to support improved management of the deteriorating patient. It is now essential to build on this work to achieve further improvements in clinical outcomes.

What did we do?

The main objective in the last year has been to achieve a further 20% reduction in 'Avoidable' cardiac arrests. To support this key outcome it has been essential to make improvements all along the deteriorating patient pathway.

To assist with identifying areas for improvement and to support clinical engagement in the improvement process, reviews of all the cardiac arrests are carried out by the resuscitation team and reviewed in conjunction with the clinical teams. Action plans are devised by the clinical teams and put in place to minimise re-occurrence of issues identified. Lessons learned are shared at clinical governance meetings, to support the wider learning from incidents. Clinical areas with the highest numbers of cardiac arrests, have reviewed the arrests occurring on their wards over the year to identify what are the lessons to be learned, in order to devise strategies to reduce the incidence of arrests occurring in those areas, .

Key objectives to achieve the reduction in cardiac arrests were:

1. 20% improvement on 2014-15 baseline for timely and appropriate observations

2. 20% improvement on 2014-15 baseline for timely escalation of concerns to medical staff

3. 20% improvement on 2014-15 baseline for medical response times

4. 20% improvement on 2014-15 for failure to take appropriate action to prevent further deterioration.

5. Improvement in appropriate timely clinical decision making regarding Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) / Treatment Escalation Plans / Personal Resuscitation planning.

Objective 1 Wardware our electronic observations system has been used to support timely and appropriate patient observations. The aim is that each patient has a monitoring plan set around their individual and changing requirements, and that this plan is adhered to.

A Standard Operating Procedure (SOP) has been implemented which sets out the roles and responsibilities for all the nursing healthcare team regarding management of the deteriorating patient. It also sets out an acceptable timeframe for overdue observations, and compliance is measured for each patient against their monitoring plan. Feeding back compliance rates to wards where there have been concerns has promoted a more reliable observation process.

Objective 2 To support a timely escalation process an escalation protocol has been devised and implemented. Staff are encouraged to use the communication tool SBAR (Situation, Background, Action, Recommendation), when escalating concerns regarding deteriorating patients.

Objective 3 and 4 To support a timely and appropriate response and action by medical staff when managing the deteriorating patients. Case scenarios regarding cardiac arrests are shared with junior doctors to explore issues related to the management of the deteriorating patient. This provides the junior doctors with an opportunity to review cardiac arrest case studies in a safe and learning environment.

Objective 5 Themes from the cardiac arrest Root Cause Analysis (RCA) have highlighted that at times there are concerns regarding the timeliness of the decision making of the medical teams. Specifically the use of Do Not Attempt Resuscitation (DNAR) and Personal Resuscitation Plans could be improved upon as they are not always completed with appropriate ceilings of care for patients. The Resuscitation committee are leading a stream of work, and clinicians from all Divisions are attending training at University College London Hospital. The training provides guidance in having difficult conversations, it includes the legal and ethical position regarding DNAR decisions. A Grand Round session is to be held. University College London are attending to facilitate the training to the attending medical staff. It is anticipated that this will help resolve many of the concerns of senior clinicians about ethical and legal issues regarding DNAR decisions, enabling them to make more timely decisions for appropriate patients.

How did we perform?

The delivery of the improvement programme to safely and effectively manage the deteriorating patient has made notable improvements right across the deteriorating patient pathway. There has been a reduction of 42% in the inpatient cardiac arrest rate. Further work needs to be undertaken over the next year to ensure that the Trust devises strategies to sustain this improvement.

Key Patient Safety Priority 4

Reduce avoidable harm by ensuring a patient's current medicines are correctly identified, communicated and prescribed at admission

Why was this a priority?

Considerable evidence exists to demonstrate that mistakes can be made in correctly identifying and recording patient's current medicine history when they transfer from one care setting to another – for example from a residential care home into an acute hospital. This can lead to patients missing critical medicines which can result in extra interventions during their inpatient stay and lead to a longer hospital stay.

What did we do?

- Used the implementation of Electronic Prescribing and Medicine Administration (ePMA) system to develop a 'Pharmacist Friend' dashboard to support identification and prioritisation of patients for medicines reconciliation based on their risk of adverse medication events
- A business case was written and presented to the Medical Division to expand provision of pharmacy- led medicines reconciliation for all emergency patients within 24 hours of admission, 7 days a week as part of the Medical Division's project to move to a Keogh compliant 7 day working medical model. This business case was incorporated into the larger Needs Based Care business case. A decision on funding is still awaited.

How did we perform?

- More than 85% of patients identified, using the risk prioritisation tool as at high risk of medication related adverse events, received a pharmacy- led medicines reconciliation at some point within their inpatient stay.

Priority 3: Patient Experience

Key Patient Experience Priority 1

Implement patient focused booking systems including self check-in and partial booking of outpatient clinics

Why was this a priority?

Patient experience is currently impacted by manual 'checking in' processes when attending outpatient appointments, involving patients queuing at busy reception desks, potentially leading to delays and clinic inefficiencies. There is opportunity to modernise booking systems through introducing self-check-in and to improve access and choice in scheduling patients' follow up appointments by introducing partial booking.

What did we do?

The outpatient administration department has worked closely with the Divisions of Medicine and Surgery to implement a pilot across several clinical specialties to introduce partial booking. This change to the appointment booking process facilitates improved transparency and management of waiting lists, allows for better service planning and more effective response to fluctuations in demand, and benefits patients with improved choice of access. On the basis of a successful pilot and subsequent business case, Outpatients will be implementing partial booking across the Trust over the course of 2016/17.

The Division successfully tendered for the procurement of an automated self check-in system across Outpatients in 2015. In view of the corporate need to progress the business case for and replacement of the Trust's current Patient Administration System (PAS) the decision was taken to pause implementation of a self check-in system and combine it with the introduction of the new PAS, so that the systems are compatible and we maximise our use of resources.

How did we perform?

Roll out of partial booking was achieved across several clinical specialities in 2015/16, including Rheumatology, ENT, Respiratory, Trauma and Orthopaedics and Urology. This accounts for about one third of Trust activity. Recruitment to achieve the resource required for a full roll out plan across the Trust is underway. The Trust achieved 33% of clinics using partial booking (against the planned 50%) and aims to have 90% achieved by the end of 2016/17.

We have also seen substantial reductions in DNA rates achieved, with follow up DNA rates from April 2015 to the present across those specialties that have gone live with partial booking showing an overall reduction of 1.6%. The target is to achieve an overall Trust follow up DNA rate reduction of 2% in 2016/17 with full implementation of partial booking.

The incidence of hospital initiated rescheduling appointments by the Trust (as opposed to when a patient chooses to move their appointment) has also been reduced in the specialties where partial booking has been introduced, improving patient experience and contributing to additional clinic capacity and attendances.

A comparison of data from Quarter 4 2014/15 to Quarter 4 2015/16 in Rheumatology, ENT, Respiratory, Trauma and Orthopaedics and Urology shows that:

1. First appointment moves have reduced from 3.1% down to 1.4%
2. Follow up appointment moves have reduced from 13.5% to 1.6%

The Trust was unable to progress self check-in and clinic tracking in 2015/16 due to the re-evaluation of the options of a replacement patient administration system.

Key Patient Experience Priority 2

Improve the experience and care of patients at the end of life and the experience for their families

Why was this a priority?

Improving end of life care (EOL) is a priority if we are to ensure the best possible quality of care to our patients and their families. The most sensitive and difficult decisions that clinicians have to make are around the starting and stopping of potentially life prolonging treatment. There is a need to encourage a culture change across the organisation. We need to be open to and not fearful of discussion regarding death and dying. Once these decisions are made, it is crucial that our patients receive optimum end of life care. This was a key priority for the Trust last year where we re-designed the multidisciplinary documentation and delivered a Trust-wide communication and teaching programme to nurses and doctors. This year, the focus will be on advanced care planning, improved communication with patients and families and improved symptom management and spiritual care.

What did we do and how did we perform?

Strengthened resource and communication
Investment in the Palliative Care Team has been strengthened to include a team leader who will focus on clinical leadership supported by two band 7 Clinical Nurse Specialists. In addition to this, an End of Life Nurse has been employed following a successful Macmillan bid. This role is crucial and focuses on promoting appropriate (EOL) care on all the adult wards. This nurse sees every EOL patient in the Trust to ensure that best care is being delivered. The full team was in place by November 2015.

Both the Palliative Care Team leader and the Palliative Care consultant have presented at the Grand Round to update consultants regarding the national agenda for the improvement of palliative care. In addition, the Palliative Care team leader has presented to various medical groups promoting this agenda. The Matron for Cancer services, and Palliative Care, has also provided training and updated groups of senior nurses. Members of the Palliative Care team presented improvements to EOLC at a public meeting of our Foundation Trust members in December, which was very well received.

The End of Life Strategy group membership has been broadened to include more decision makers who can implement change throughout the Trust, and also includes CCG representation. Collaborative working with community colleagues has been strengthened by introducing a daily conference call with the Keech Hospice to ensure access to hospice beds for appropriate patients.

Improved the recognition of End of Life
The Palliative Care team and the Resuscitation team have worked with Consultants to improve the way we use our 'Personal Resuscitation Plans' (PRPs) more effectively. This enables the identification of triggers for recognising those patients who may be dying thus allowing for more timely discussions with patients and families regarding DNACPR (Do not attempt Cardio-pulmonary Resuscitation). To ensure that PRPs are used effectively, a prompt for the dying patient has been added to the DNACPR form.

Improved care planning
Collaborative working with the Emergency Department (ED) has enabled the introduction of the End of Life Care pathway for the department. ED are also monitoring palliative patients who have been inappropriately referred to ED and following investigation have shared the lessons that can be learned to prevent patients from dying in the ED. These cases are reported and shared with other providers and commissioners at the End of Life Strategy Meeting. It is intended that the themes will be taken to our regional meetings to understand and improve services.

The 'Individualised Care plan for the Dying Patient' was introduced at the beginning of the year and used throughout the Trust as a replacement for the Liverpool Care Pathway. It complies with national guidelines and has been shown through audit to be helping improve the use of appropriate anticipatory prescribing to reduce palliative symptoms. This was reviewed and updated in December and its use continues to improve EOLC delivery.
A 'Must Do' card for palliative care patients has been produced to remind clinical teams of the essential steps in complying with national guidelines around the EOL care plan. These have been distributed throughout the Trust to every clinician and nurse.

A guidance to anticipatory medications was devised by our palliative care consultant and palliative team leader and is available on the intranet as well as on the wards in a palliative care folder. In addition to this, an information folder has been produced and is now available on all wards containing a wide range of literature to support staff, patients and relatives. The palliative care team are also ensuring all patients and carers are offered an information pack.
The palliative team have made efforts to engage more fully with the chaplaincy team within the trust. As they have also gained additional staff a chaplain has now joined the palliative MDT as a core member. In addition to this chaplaincy representation will be joining the LIG spirituality task and finish group, and also now attends the Trust EOLC Strategy group.

How did we perform?

The Trust received the Care of the Dying National Audit at the end of March 2016. The audit identified areas that we are performing well and areas for improvement.

- Although it is often difficult to communicate with patients when they are receiving end of life care, 82% of people important to the patient were given opportunities to discuss care – this is above national average and is an improvement.
- The Trust has seen a reduction in the cardiac arrest rate from 1.6 per 1000 discharges in 2014/15 to 1.04 in 2015/16
- Patient information has been improved and patients and families are now given an information pack by SPC team and information leaflets are available on each ward. The Bereavement Survey is planned for 2016/17.
- Work still needs to be done on improving symptom control particularly with regard to prescribing anticipatory medication. The National Audit result is mixed, with some improvements noted and some further improvement required. However we have launched our anticipatory medications guideline to support improvements in this area.
- National audit still shows spiritual needs assessments require further improvement and the Trust is developing the EOLC volunteer service to support this work. The chaplaincy service now document the care they have provided in the patient notes.

Key Patient Experience Priority 3

Ensure there are processes in place to sustain improvement in timely assessment, diagnosis and support for people with dementia and delirium

Why was this a priority?

Patients with dementia and delirium can experience some or all of the following: memory loss, language impairment, disorientation, changes in personality, which leads to difficulties with activities of daily living, and complex care needs. In the later stages of the disease, there are high levels of dependency and morbidity. These care needs often challenge the skills and capacity of carers and services. It is essential therefore that we identify these patients early in their in-patient stay, provide good quality patient care and experience whilst they are in hospital and plan effectively with primary care for their discharge.

What did we do?

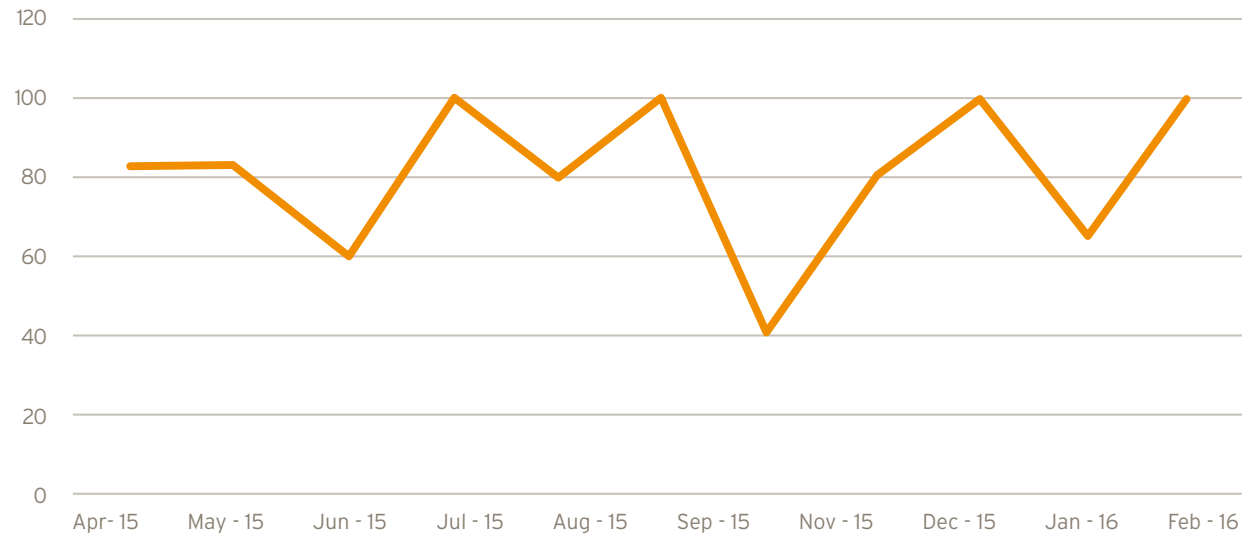
We continued to assess patients aged over 75 who were admitted to hospital as part of a National Dementia screening programme.

- Any person with a positive screening was offered a management plan and further screening either as an inpatient or as a recommended plan for primary care services on discharge.
- A working group was established to share, develop and review organisational care pathways across Bedfordshire and review.
- The content of the hospital Electronic Discharge Letter (EDL) was reviewed to provide sufficient information for the GPs with information that would help develop the plan of care for any patients newly diagnosed with Dementia while in hospital.
- The Clinical Nurse Specialist (CNS) for Dementia developed an education strategy aligned with the National framework. All staff with a substantive post were offered Dementia awareness education booklet. All mandatory training now includes Dementia awareness. Collaborative work with care providers in the community includes inviting community staff to relevant training. Information of where and how to access free training is available.
- The CNS for Dementia is involved in provider forums and quality assessment of care homes in Central Bedfordshire, which monitors the staff training and level of awareness.
- A carer's survey has been carried out over the past year to collect feedback across the local pathway. Action plans and action logs are provided to CCGs as part of our local CQUIN.

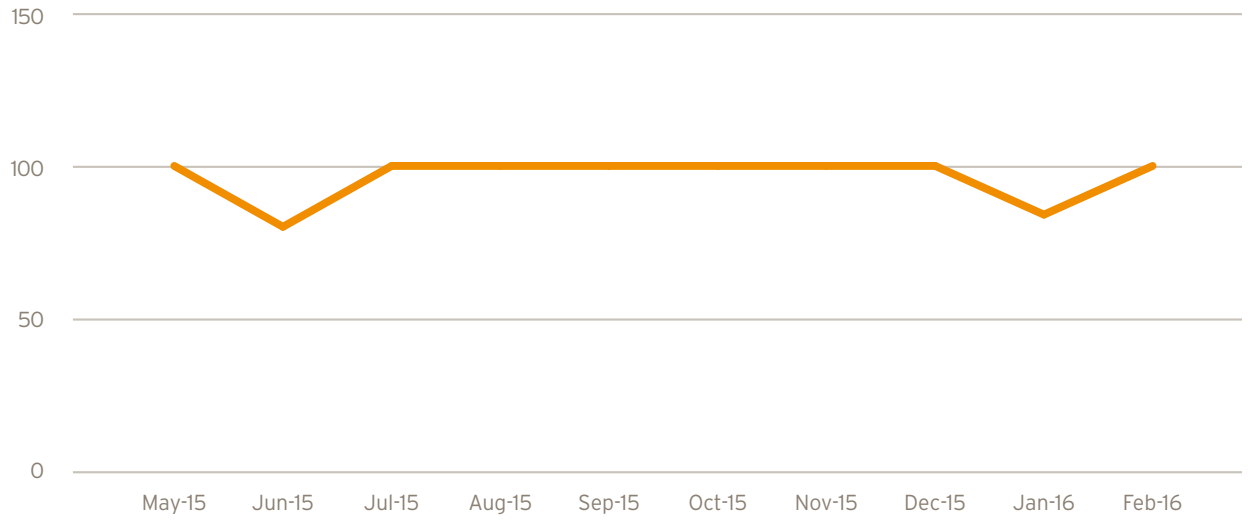
How did we perform?

- The Trust was compliant with over 95% of screening taking place each quarter; 90% compliance with onwards referrals and recommendations for patients with cognitive dysfunction in line with local pathways.
- A robust training plan has been implemented and all 4000 staff were given a dementia awareness booklet in February 2016. Feedback is being collected and is generally positive.
- Feedback is on-going and evidence of the impact of training will be evaluated using patient and carer feedback, complaints, compliments and incidents. Staff comments and feedback on the impact training is being gathered.
- Feedback has been received from the carers survey which refers to aspects of care in hospital and the wider health economy. This information is being used to inform local commissioners of any areas of improvement recommended by the carers of people with dementia. Each organisation has evaluated its findings and discussed themes to report.

% Carers who felt they had been consulted about the care provided to the person with Dementia



% of carers who felt the person with Dementia was treated with respect and dignity.



The main themes for the Trust have included being 'updated and involved in care'. In response the CNS for Dementia has proposed that the Trust supports the national 'Johns Campaign' which focuses on the rights of carers to stay with a person with dementia while they are in hospital and to relax standard visiting hours. Our Board has agreed to this. Adopting 'John's Campaign' will have a positive impact on the wellbeing and recovery patients with dementia, with the potential to reduce harms, reduce the number of patients who need 'specialling' – where a member of staff is allocated to monitor the patient so they are not able to harm themselves or wander - improved patient satisfaction, patient experience and reduced length of stay.

Our hospital carers packs have been reviewed and information added to improve access to community support.

This priority was a national CQUIN and the Trust achieved the requirements.

3. Priorities for Improvement in 2016/17

Improving clinical outcomes, safety and experience for our patients while delivering value for money is key to the Trust's overarching quality strategy. To meet the short term challenges that we face, we have developed a number of ambitious Trust-wide quality priorities. These are based on local as well as national priorities including the need to ensure ongoing CQC compliance and to implement the recommendations from our own internal review of the Francis, Berwick and Keogh reports.

An additional focus on transforming our workforce to deliver our new ways of working and quality priorities will be performance managed across clinical divisions to ensure improvements. The Trust recognises that this transformation of services will be challenging and the overall plan and key risks for achieving these quality priorities will be monitored by the Trust Board's Quality Committee.

We have key priorities each for clinical outcome, patient safety and patient experience

Priority 1: Clinical Outcome

Key Clinical Outcome Priority 1

Improve the management of patients with acute kidney injury (AKI)

Why is this a priority?

AKI is a sudden reduction in kidney function. As well as being common, AKI is harmful and often preventable, thus representing a major patient safety challenge for health care. It is a major factor in increasing patients' length of stay and can contribute to significantly increased mortality. This was a key priority for the Trust last year where we focused on implementing a Trust wide electronic system to improve detection, developed an AKI management care bundle and improved AKI diagnosis and treatment.

What will we do?

Building on this work, there are three key priorities for this year. These will focus on:

- Working collaboratively with UCL Partners, (as part of our sign up to safety work), to devise optimum 'standards for recognition and treatment' of AKI.
- Improving the use of fluid balance charts to ensure an accurate record of fluid intake and output and an early escalation score.
- Providing a plan of care for the GP to monitor kidney function after discharge.

These objectives will be delivered by:

- Supporting the continued use of the AKI clinical management bundle (evidenced based clinical interventions) which provides clear guidance on the steps to take in managing patients presenting with AKI
- In conjunction with UCLP collaborative implement 'Standards for recognition and treatment' of AKI', and devise and implement appropriate improvement strategies.
- Provide Multidisciplinary team (MDT) education and training to support early recognition and effective management of patients presenting with AKI
- Identify standards for fluid charting to improve the use of fluid charts to ensure an accurate record is made of patient's fluid intake and output
- Devise and implement an improvement programme to improve the accuracy of fluid charting.
- Providing a plan of care for the GP to monitor kidney function after discharge

How will improvement be measured and reported?

Overall performance and assurance will be reviewed by the Clinical Outcome, Safety and Quality committee and subsequently reported to the Board on a monthly basis.

Success Criteria

- Continued and improved use of AKI Alerting system
- Implementation of the standards for recognition and treatment of AKI.
- Monitor compliance with AKI standards
- Provision of a plan of care to monitor patients identified with AKI whilst in hospital after discharge
- Establish a baseline for accuracy of fluid charts.

Key Clinical Outcome Priority 2

Improve the management of patients with severe sepsis

Why is this a priority?

Sepsis is a common and potentially life threatening condition where the body's immune system goes into overdrive in response to infection. Sepsis is recognised as a significant cause of mortality and morbidity in the NHS. Problems in achieving consistent recognition and rapid treatment of sepsis are currently thought to contribute to the number of preventable deaths from sepsis. Early detection and effective management of patients presenting with sepsis will reduce morbidity and mortality.

What will we do?

The Trust will build on the work commenced in emergency care in 2015 with a particular focus on:

- Embedding the timely delivery of the sepsis bundle to all patient groups presenting as an emergency
- Implementing the use of the sepsis screening tools for patients who develop sepsis as an inpatient
- Commencing rollout of the sepsis care bundle to patients developing sepsis as an inpatient

How will improvement be measured and reported?

Overall performance and assurance will be reviewed by the Executive Board, Clinical Outcome, Safety and Quality committee and subsequently reported to the Board on a monthly basis.

Success Criteria

- Compliance with appropriate sepsis screening (audit) for emergencies and ward -based patients.
- Timely compliance with antibiotic delivery for patients presenting with severe sepsis and septic shock (audit) for emergencies and ward -based patients.

Key Clinical Outcome Priority 3

Improve our approach to mortality surveillance, identifying and reducing avoidable deaths

Why is this a priority?

The Trust's 12 month rolling HSMR remains statistically high, but the monthly trend has seen 5 consecutive months of improvement within expected ranges. It is likely that the 12 month HSMR will remain elevated until the particularly high values seen in January, April and May 2015 fall out of the indicator. This monitoring and reduction of our HSMR remains a critical priority in the year ahead.

What will we do?

The Trust Mortality Board will oversee the delivery of:

- The refinement and embedding of our ongoing review of all mortality to identify avoidable deaths. This aligns with the national initiative by Sir Bruce Keogh, to which we will continue to report our findings.
- The Trust will complete on-going reviews for trends and correlations within our clinical information. Using external benchmarks, particularly the newly available SHMI by diagnosis type, we will review all areas of concern.
- The Trust will respond to the findings of the external quality assurance of our mortality surveillance processes commissioned at the end of 2015/16. In this manner the Trust intends to improve our benchmarked mortality to the upper quartile of performance.

How will improvement be measured and reported?

Overall performance and assurance will be reviewed by the Clinical Outcome, Safety and Quality committee and subsequently reported to the Board on a monthly basis.

Success Criteria

- Improving HSMR
- On-going review by the Mortality Board

Key Clinical Outcome Priority 4

Reduce our antibiotic consumption

Why is this a priority?

Antimicrobial resistance (AMR) has risen over the last 40 years and inappropriate and overuse of antimicrobials is a key driver. The number of new classes of antimicrobials coming into the market as reduced in recent years and between 2010 and 2013, the total antibiotic prescribing has increased by 6%. This leaves the prospect of reduced treatment option when antimicrobials are life-saving and standard surgical procedures could become riskier with widespread antimicrobial resistance.

What will we do?

For 2016/17, the Trust has an AMR CQUIN that:

- Aims to reduce total antibiotic consumption and also the reduction in the use of certain board-spectrum antibiotics.
- Focuses on antimicrobial stewardship and ensuring antibiotic review within 72 hours

How will improvement be measured and reported?

Overall performance and assurance will be reviewed by the Clinical Outcome, Safety and Quality committee and subsequently reported to the Board on a monthly basis.

Success Criteria

- A baseline of antibiotic consumption (audit)
- Implementation of a process for antibiotic reviews within 72hrs.

Priority 2: Patient Safety

Key Patient Safety Priority 1

Ongoing development of Safety Thermometer, improving performance year on year

Why is this a priority?

The NHS Safety Thermometer continues to provide nurses with a point of care survey tool to check fundamental levels of care identify where things go wrong and take prompt action. It is used by nurses to measure and track the proportion of patients in our care with pressure ulcers, urinary tract infections, VTE and who have incurred a fall and sustained harm. In addition to collection of this prevalence data, the Trust will also continue to monitor and improve the incidence of these key harms.

What will we do?

- **Pressure Ulcers.** The Trust will continue to reduce the numbers of category 2&3 hospital acquired avoidable pressure ulcers. Having achieved a 65% reduction in incidence from hospital acquired grade 3 pressure ulcers over the last two years, the focus for 2016 will be further reducing grade 2 pressure ulcers. This will be achieved through supporting and educating nursing staff across the organisation on the early identification, prompt validation and subsequent management of skin breakdown and continually learning through the Root Cause Analysis (RCA) process. The Tissue Viability team will also continue to participate in the countywide pressure ulcer group to share learning to enable a further reduction of both community and hospital acquired pressure ulcers.

- **Falls.** Whilst some falls are avoidable, reducing falls in an ageing and more frail population with complex health needs, is very challenging. To date the Trust has been successful in reducing the overall number of falls and the challenge for 2016 is to reduce the number of falls that result in severe harm. This will involve improved risk assessment and management of the frail elderly and working closely with the Falls and Dementia nurse specialist on this more vulnerable group of patients.

- **Catheter Related Urinary Tract Infections.** We will aim to reduce the number of patients who develop a urinary tract infection through use of a urinary catheter. The focus during the year will be targeting areas where high use is noted.

- **VTE.** Hospital acquired Venous Thromboembolism (VTE) is an important patient safety issue resulting in significant mortality, morbidity and healthcare resource expenditure. In addition to ensuring that all relevant patients will be risk assessed, prescribed and administered the appropriate preventative treatment, the sharing of lessons learnt from any hospital acquired thrombosis will be the key focus.

How will improvement be measured and reported?

Overall performance and assurance will be reviewed by the Clinical Outcome, Safety and Quality committee and subsequently reported to the Board on a monthly basis.

Success Criteria

- The data set from the Safety Thermometer tool will be collected, collated and reported on providing the Trust with a snapshot (prevalence) of the four key 'harms', occurring on a particular day each month in the Trust. These data in conjunction with additional incidence data will then be used to drive improvements in practice and will be reviewed bi monthly as part of the nursing quality assurance framework. Overall performance and assurance will be reviewed by the Clinical Outcome, Safety and Quality committee and reported to the Board.
- Further reduce incidence of grade 2 pressure ulcers.
- Maintain the current position in providing 98% or above in new harm free care (95% in 2013/14, 97% in 2014/15 98% in 2015/16))
- Maintain the current prevalence of patients who experience a fall and incur harm
- Aim that no more that 16% of all inpatients will have a urinary catheter
- Maintain 95% (minimum) patients to have had a VTE risk assessment and those that are identified as at risk of developing a thrombosis are provided with appropriate prophylaxis

Key Patient Safety Priority 2

Improve the management of the deteriorating patient

Why is this a priority?

The recognition of acute illness is often delayed and its subsequent management can be inappropriate. This is because clinicians' may fail to monitor, document or act on physiological abnormalities in a timely way, commonly described as "Failure to Rescue". This in turn leads to further deterioration in the patient's clinical condition and potential death. Although the Trust's average cardiac

arrest rate continues to be lower than the national average, analysis of the cardiac arrests for 2015/16 has highlighted some areas for improvement. This includes earlier identification of the deteriorating patient by timely and appropriate observations and prompt medical action to prevent further deterioration.

What will we do?

This has been a key Trust quality priority for two years and this year the focus will be on:

- Improving the identification of the deteriorating patient that is dying. This will be enabled by increasing and improving the setting of appropriate ceilings of care, the use of Personal Resuscitation Plans and where appropriate and timely DNAPR. To achieve this objective it has been identified that it is necessary to provide training and education to senior medical staff. The training provided will need to cover guidance in having difficult conversations, and the legal and ethical position regarding DNARCP. The Trust are working closely with UCLP to deliver this training.

How will improvement be measured and reported?

Overall performance and assurance will be reviewed by the Clinical Outcome, Safety and Quality committee and subsequently reported to the Board on a monthly basis.

Success Criteria:

- Sustain overall improvement in cardiac arrest rate to maintain Trust position below National cardiac arrest baseline.
- To continue to sustain improvements all along the deteriorating patient pathway ensuring:
  1. Timely and appropriate observations
  2. Timely escalation of concerns to medical staff
  3. Timely medical response times,
  4. Improvement in timely and appropriate decision making by medical staff.

Key Patient Safety Priority 3

Further development of stroke services
Why is this a priority?

Central to the Trust strategy to become a 'Hyper-Acute Emergency' hospital, is to deliver optimum stroke care through further investment in our 'Hyper-Acute' stroke Unit. Following an increase in therapies staffing and an additional two Stroke Physicians, 2016 will focus on the recruitment of additional speech and language staff and a senior Clinical Nurse Specialist to improve nurse leadership and ensure all performance targets are met. Data capture for SSNAP will be improved to ensure that all activity and key clinical interventions are accurately recorded. More ambitiously, the senior nursing team in conjunction with the new specialist nurse will design a revised educational programme to train nurses in key competencies. Multi-agency working will focus on further developing our repatriation policy to improve direct access to the unit.

What will we do?

An important factor in the successful implementation of evidence-based stroke care will be the emphasis on staff taking ownership of how to translate the goals of various policies into practice. For example, the physiotherapists will be encouraged to perform their own team goal-setting and to devise their strategies for meeting targets such as the 72-hour assessment. The speech and language therapy staff will be involved in adapting guidelines to their own specific practice. A commitment to multidisciplinary team working underpins all these initiatives.

How will improvement be measured and reported?

Overall performance and assurance will be reviewed by the Clinical Outcome, Safety and Quality committee and subsequently reported to the Board on a monthly basis.

Success Criteria:

- Improved compliance with the Sentinel Stroke Audit (SSNAP)

Priority 3: Patient Experience

Key Patient Experience Priority 1

Improve the experience and care of patients at the end of life and the experience for their families
Why is this a priority?

Improving End of Life Care is a priority if we are to ensure the best possible quality of care to our patients and their families. The most sensitive and difficult decisions that clinicians have to make are around the starting and stopping of potentially life prolonging treatment. There is a need to encourage a culture change across the organisation. We need to be open to and not fearful of discussion regarding death and dying. Once these decisions are made, it is crucial that our

patients receive optimum end of life care. The last two years have seen improvements in communication with patients and families, improved symptom management and spiritual care, investment in training and education and reduction in inappropriate cardiac arrests through more timely decisions regarding DNACPR. This year, the focus will be on working with our community colleagues and our commissioners to ensure patients achieve their choice of 'place to die' and that this is achieved in a timely manner.

What will we do?

- Continue to build and develop the Palliative Team raising the profile of specialist palliative care expertise and the new EOLC Nurse role.
- Continue to present to clinical meetings across the multidisciplinary teams in order to promote the EOL Individualised Care plan and embed the national guidelines of palliative care. In particular helping to identify the dying patient and foster appropriate, timely conversations around EOL.
- Continue to promote "small things make a difference"- i.e. introduction of new linen patient property bags.
- Continue to strengthen the EOL Strategy Group making it a robust steering group for the delivery of palliative care standards we can be proud of.
- Supporting our staff on the wards and promoting our ethos that palliative care is everyone's business from the cleaner to the consultant.
- Improve communication through additional and improved leaflets available to our patients.
- Gather palliative champions on each ward and equipping them to be advocates and role models of palliative care.
- Work with our chaplaincy team to improve the delivery of good spiritual and religious care to this cohort of patients, family and friends.
- Continue to audit of the EOL Individualised Care Plan and enhancing its correct use.
- Gather feedback on patient and carers experience.

How will improvement be measured and reported?

Overall performance and assurance will be reviewed by the Executive Board and the Clinical Outcome, Safety and Quality committee and subsequently reported to the Board on a monthly basis.

Success Criteria

- Improved performance in the national 'Care of the Dying' audit
- Improved performance in the further local audits of the EOL Individualised Care Plan
- A reduction in incidents and complaints through the End of Life Steering Group
- Continued improved feedback from patients and carers

Key Patient Experience Priority 2

Ensure there are processes in place to sustain improvement in timely assessment, diagnosis and support for people with Dementia and Delirium

Why is this a priority?

Patients with Dementia and Delirium can have complex care needs. These care needs often challenge the skills and capacity of carers and services. It is essential therefore that we identify these patients early in their in-patient stay, provide good quality patient care and experience whilst they are in hospital and plan effectively with primary care for their discharge.

What will we do?

This has been a key quality priority for the Trust for some years with improvements in timely assessment, referral, treatment and support for carers. 2016 will focus on delivering the Trust dementia strategy through the following priorities:

- Working with the primary care services (our GPs) to improve the information they receive from our Consultants. This will enable the GPs to prioritise those patients who are more complex and require immediate support in the community
- Ensuring that appropriate dementia training is available to all staff and work with the commissioners to deliver a collaborative training programme across the local health and care economy
- The impact of the environment on the person with dementia will be recognised as a fundamental influence on the wellbeing and recovery of the patient. The redevelopment of the hospital site will embrace dementia friendly design where appropriate by promoting an enabling and safe environment.

How will improvement be measured and reported?

Overall performance and assurance will be reviewed by the Clinical Outcome, Safety and Quality committee and subsequently reported to the Board on a monthly basis.

Success Criteria

- Reduction in the number of falls for a patient with Dementia
- Maintain and increase the number of staff with appropriate knowledge and skills training

- Reduced number of emergency re-admissions within 30 days
- Maintain good feedback on overall quality and experience from carer/ patient survey

Key Patient Experience Priority 3

Completing the Roll Out of Partial Booking across the Trust

Why is this a priority?

Outpatients have successfully completed the pilot of partial booking in several specialties in Medicine and Surgery over the course of 2015/16. The initiative that has worked well for clinicians, business managers and most importantly, our patients. Partial booking has brought substantial benefits in terms of improved waiting list management and service capacity planning, reducing the multiple rescheduling of patient appointments and reducing DNA rates in these specific specialty areas.

What will we do?

This next year will focus on the roll out of the programme across the whole of the Trust, providing increased momentum to enabling the Trust to further improve efficiency in appointment scheduling and reduce the volume of missed appointments.

How will improvement be measured and reported?

Overall performance and assurance will be reviewed by the Clinical Outcome, Safety and Quality committee and subsequently reported to the Board on a monthly basis.

Success Criteria

- Reduce the volume of missed appointments to 8%.

4. Statements related to the Quality of Services Provided

4.1 Review of Services

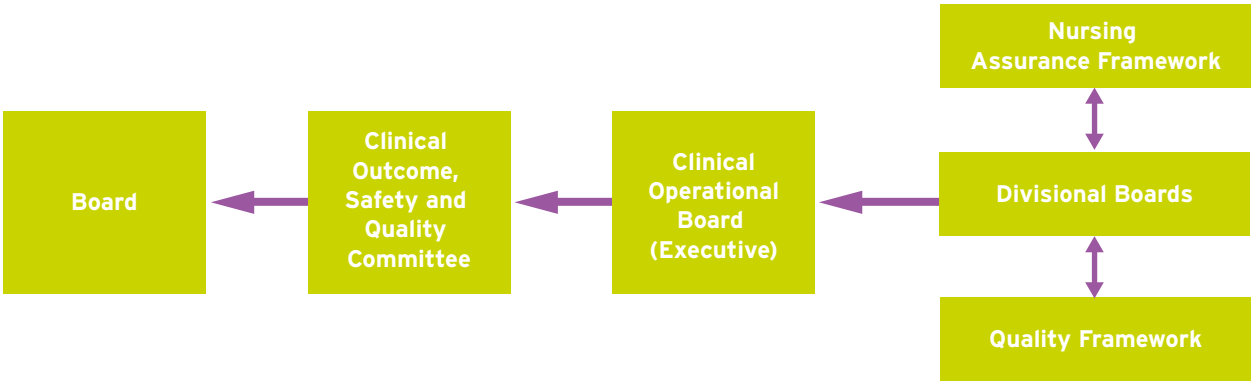
During 2015/16 the Luton and Dunstable University Hospital NHS Foundation Trust provided and/or sub-contracted 47 clinical services. We have reviewed all of the data available to us on the quality of care in all of these NHS services as part of our internal and external management and assurance processes. The Board of Directors considers performance reports every two months including progress against national quality and performance targets. The Board also receives reports from the Clinical Outcome, Safety and Quality sub committee. Quality is managed by the Divisional Boards and the Clinical Operational Board providing assurance to the Clinical Outcome, Safety and Quality Committee.

These reports include domains of patient safety, patient experience and clinical outcome. During 2014/15 the Executive Board commissioned a number of external experts and external reviews to support its work and to ensure the Trust was aware of best practice nationally and internationally. The reviews included:

- An external review of the Trust's approach to mortality reviews
- The Transforming Quality Leadership programme
- An external CQC style peer review as part of our Nursing Quality Framework

In addition, the Board receives reports relating to complaints and serious incidents.

Quality Assurance Monitoring



The income generated by the NHS services reviewed in 2015/16 represents 100% of the total income generated from the provision of NHS services by the Luton and Dunstable University Hospital NHS Foundation Trust for 2015/16.

4.2 Participation in Clinical Audits and National Confidential Enquiries

During the period the Trust was eligible to participate in 36 of the 56 National Clinical Audits that met the Quality Accounts inclusion criteria.

The Trust participated in 32 (two partially) (89%) of the eligible national audits

The following 3.5 audits which we were eligible but did not participate are:

- National Audit of Intermediate Care - due to Divisional restructure
- National Diabetes Audit - due to software issues. Anticipated participation in 2015/16 dependant on installation of Diamond database
- National Ophthalmology Audit - due to software issues. Business Case for the Electronic Patient Records system called Medisoft submitted
- UK Parkinson's Audit - DME/Neurology participated - Therapies were not aware of their elements of the audit
- National Comparative Audit of Blood transfusion programme – One audit completed and departmental pressures meant the team were unable to complete the second audit

Clinical audits are a mixture of National and local priorities which each directorate is responsible for as part of their Clinical Audit Forward programme. The data collected for Quality accounts includes mandatory audits on the National Clinical Audit and Patient Outcomes Programme which directorates must participate in. Other audits whether local or national may not have been deemed as high priority or reflects the audits which directorates have prioritised.

Details are provided within the table on pages 179-183

Name of audit / Clinical Outcome	Organisation	Eligibility and participation	Data Period	Cases Required	Cases Submitted
Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)	National Institute for Cardiovascular Outcomes Research (NICOR)	Eligible Yes Participated Yes	Apr 2015 - Mar 2016	All patients with diagnosis of MI	Will be completed ahead of deadline (July 2016)
Adult Cardiac Surgery	National Institute for Cardiovascular Outcomes Research (NICOR)	Eligible No			
Bowel Cancer (NBOCAP)	Royal College of Surgeons	Eligible Yes Participated Yes	Apr 2015 - Mar 2016	All	All (100%)
Cardiac Rhythm Management (CRM)	National Institute for Cardiovascular Outcomes Research (NICOR)	Eligible Yes Participated Yes	Apr 2015 - Mar 2016	100%	Jan - Dec 2015 - 162 cases submitted
Case Mix Programme (CMP)	Intensive Care National Audit and Research Centre (ICNARC)	Eligible Yes Participated Yes	Apr 2015 - Mar 2016	All ITU Admissions	396 Cases (100%)
Congenital Heart Disease (CHD)	National Institute for Cardiovascular Outcomes Research (NICOR) Adult and Children	Eligible No			
Coronary Angioplasty/National Audit of Percutaneous Coronary Interventions (PCI)	National Institute for Cardiovascular Outcomes Research (NICOR)	Eligible Yes Participated Yes	Apr 2015 - Mar 2016	All PCI	270 Cases
Diabetes (Paediatric) (NPDA)	Royal College of Paediatrics and Child Health	Eligible Yes Participated Yes	Apr 2015 - Mar 2016	All eligible cases	Data collection in progress. 100% (153 cases will be submitted by June 2016)
Elective Surgery (National PROMs Programme)	Health & Social Care Information Centre	Eligible Yes Participated Yes	Apr 2015 - Mar 2016	All eligible cases	Total cases submitted 43 (Primary Hip Replacement:7, Primary Knee Replacement: 14, Groin Hernia: 20, Varicose Veins: 2
Emergency Use of Oxygen	British Thoracic Society	Eligible Yes Participated Yes	Apr 2015 - Mar 2016	30+30+1	15

Name of audit / Clinical Outcome	Organisation	Eligibility and participation	Data Period	Cases Required	Cases Submitted
Falls and Fragility Fractures Audit programme (FFFAP)	Royal College of Physicians of London	Eligible Yes Participated Yes	Apr 2015 - Mar 2016	30	100%
Inflammatory Bowel Disease (IBD) programme	IBD Audit managed by Royal College of Physicians **Transitioning to** IBD Registry managed by the British Society of Gastroenterology	Eligible Yes Participated Yes	Apr 2015 - Mar 2016	20	20
Major Trauma Audit	The Trauma Audit and Research Network (TARN)	Eligible Yes Participated Yes	Apr 2015 - Mar 2016	All cases	158 Cases submitted
Maternal, Newborn and Infant Clinical Outcome Review Programme	MBRRACE-UK - National Perinatal Epidemiology Unit (NPEU)	Eligible Yes Participated Yes	Apr 2015 - Mar 2016	All cases	100%
National Audit of Intermediate Care	NHS Benchmarking Network	Eligible Yes Participated No*			
National Audit of Pulmonary Hypertension	Health & Social Care Information Centre (HSCIC)	Eligible No			
National Cardiac Arrest Audit (NCAA)	Intensive Care National Audit and Research Centre (ICNARC)	Eligible Yes Participated Yes	Apr 2015 - Mar 2016	Cardiac Arrests	122 (additional x20 to be entered)
National Chronic Obstructive Pulmonary Disease (COPD) Audit programme	Royal College of Physicians 3 audits	Eligible Yes Participated Yes x2 N/A x1	Apr 2015 - Mar 2016	All	100%
National Comparative Audit of Blood Transfusion programme	NHS Blood and Transplant	Eligible Yes Participated Yes (partially)	Apr 2015 - Mar 2016		
National Complicated Diverticulitis Audit (CAD)	The National CADS project	Eligible No			

Name of audit / Clinical Outcome	Organisation	Eligibility and participation	Data Period	Cases Required	Cases Submitted
National Diabetes Audit - Adults	Health and Social Care Information Centre (HSCIC) 4 audits	Eligible Yes Participated Yes x 2 N/A x 1 No x 1	Apr 2015 - Mar 2016	All eligible cases	100%
National Emergency Laparotomy Audit (NELA)	The Royal College of Anaesthetists	Eligible Yes Participated Yes	Apr 2015 - Mar 2016	All eligible cases	98%
National Heart Failure Audit	National Institute for Cardiovascular Outcomes Research (NICOR)	Eligible Yes Participated Yes	Apr 2015 - Mar 2016	Heart Failure Diagnosis	257 Cases Ongoing data entry
National Joint Registry (NJR)	Healthcare Quality Improvement Partnership (HQIP)	Eligible Yes Participated Yes	Apr 2015 - Mar 2016	All	100%
National Lung Cancer Audit (NLCA)	Royal College of Physicians	Eligible Yes Participated Yes	Apr 2015 - Mar 2016	All	100%
National Ophthalmology Audit	Royal College of Ophthalmologists	Eligible Yes Participated No*			
National Prostate Cancer Audit	Royal College of Surgeons of England (Clinical Effectiveness Unit)	Eligible Yes Participated Yes	Apr 2015 - Mar 2016	All	100%
National Vascular Registry	Royal College of Surgeons of England	Eligible No			
Neonatal Intensive and Special Care (NNAP)	Royal College of Paediatrics and Child Health	Eligible Yes Participated Yes	1st April 2015 and 31st March 2016	All eligible cases	All (100%)
Oesophago-gastric Cancer (NAOGC)	The Royal College of Surgeons of England (Clinical Effectiveness Unit)	Eligible Yes Participated Yes	1st April 2015 and 31st March 2016	All newly diagnosed UGI cancer patients receiving treatment will be submitted.	Not yet concluded.
Paediatric Asthma	British Thoracic Society	Eligible Yes Participated Yes	1st April 2015 and 31st March 2016	All eligible cases during November 2015	74 cases (100%)

Name of audit / Clinical Outcome	Organisation	Eligibility and participation	Data Period	Cases Required	Cases Submitted
Paediatric Intensive Care (PICANet)	University of Leeds	Eligible No			
Prescribing Observatory for Mental Health (POMH-UK)	Royal College of Psychiatrists' Centre for Quality Improvement (CCQI) 3 audits	Eligible No			
Procedural Sedation in Adults (care in emergency departments)	Royal College of Emergency Medicine	Eligible Yes Participated Yes	1st April 2015 and 31st March 2016	50-100 cases	50 cases
Renal Replacement Therapy (Renal Registry)	UK Renal Registry	Eligible No			
Rheumatoid and Early Inflammatory Arthritis	Northgate Public Services	Eligible Yes Participated Yes	1st April 2015 and 31st March 2016	All cases of early arthritis	22
Sentinel Stroke National Audit programme (SSNAP)	Royal College of Physicians 2 audits	Eligible Yes Participated Yes	1st April 2015 and 31st March 2016	All Stroke cases	100%
UK Cystic Fibrosis Registry	Cystic Fibrosis Trust	Eligible No			
UK Parkinson's Audit	Parkinson's UK	Eligible Yes Participated Partly Yes*	1st April 2015 and 31st March 2016	DME and Neurology	100%
Vital signs in children (care in emergency departments)	Royal College of Emergency Medicine	Eligible Yes Participated Yes	1st April 2015 and 31st March 2016	50-100 cases	50 cases
VTE risk in lower limb immobilisation (care in emergency departments)	Royal College of Emergency Medicine	Eligible Yes Participated Yes	1st April 2015 and 31st March 2016	50-100 cases	50 cases submitted - data to Jan 2016
Child Health Clinical Outcome Review Programme	National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	Eligible Yes Participated Yes	1st April 2015 and 31st March 2016	All eligible cases	All (100%)
Medical and Surgical Clinical Outcome Review Programme	National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	Eligible Yes Participated Yes	1st April 2015 and 31st March 2016	All eligible cases	Reported in section 4.3

Name of audit / Clinical Outcome	Organisation	Eligibility and participation	Data Period	Cases Required	Cases Submitted
Mental Health Clinical Outcome Review Programme	National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH) - University of Manchester	Eligible No			
Adult Asthma	British Thoracic Society	Eligible No			
Chronic Kidney Disease in primary care	Informatica Systems Ltd	Eligible No			
Non-Invasive Ventilation - Adults	British Thoracic Society	Eligible No			
Paediatric Pneumonia	British Thoracic Society	Eligible No			

Local Clinical Audits

In addition to the national and regional clinical audits and data bases reported within table 1-3, a total of seventeen local clinical audits were completed during the reporting period which were project managed by the Trust's Clinical Audit Department (Appendix A).

4.3 National Confidential Enquiries

	Topic/Area	Database/ Organiser	% return*	Participated Yes/No
1	Sepsis	NCEPOD	2/5 - 40%	Yes
2	Gastrointestinal Haemorrhage	NCEPOD	2/3 - 75%	Yes
3	Mental Health	NCEPOD	1/5 - 20% **	Yes
4	Maternal, Still births and Neo-natal deaths	CEMACH	100%	Yes

* The number of cases submitted to each enquiry as a percentage of the number of registered cases required by the terms of that enquiry

** This study is still open and returns being made

4.4 Participation in Clinical Research

The number of patients receiving NHS services provided by Luton and Dunstable University Hospital in 2014/2015 and who were recruited during that period to participate in research approved by a Research Ethics Committee was **708**. This research can be broken down into **143** research studies (**124** Portfolio and **19** Non-Portfolio).

Participation in clinical research demonstrates the Luton and Dunstable University Hospital's commitment to improve the quality of care we offer and to make a contribution to wider health improvement. Our clinical staff keep up-to-date with the latest treatment possibilities and active participation in research leads to improved patient outcomes.

4.5 Goals agreed with Commissioners of Services - Commissioning for Quality and Innovation

A proportion of Luton and Dunstable University Hospital income in 2015/16 was conditional on achieving quality improvement and innovation goals agreed between the Luton and Dunstable University Hospital NHS Foundation Trust and NHS Luton as lead commissioners through the Commissioning for Quality and Innovation (CQUIN) payment framework.

Commissioning for Quality and Innovation (CQUIN) is a payment framework which allows commissioners to agree payments to hospitals based on agreed quality improvement work. Through discussions with our commissioners we agreed a number of improvement goals for 2015/16.

Goals and Indicators

Indicator Number	Indicator Name	% of the Value
1	Acute Kidney Injury	10%
2a	Sepsis Screening	5%
2b	Sepsis antibiotic administration	5%
3a	Dementia - Find, assess, investigate and refer	6%
3b	Dementia - staff training	1%
3c	Dementia - supporting carers	3%
4a	Avoidable Admissions - Luton	5.6%
4a	Avoidable Admissions - Beds	2.4%
4b	Mental Health Attendances	8%
5	Clinical Navigation	10%
6	High Resource Patients - Luton	28%
6	High Resource Patients - Bedfordshire	12%
8a	Mental Health Data Coding	4%

The Trust monetary total for the associated CQUIN payment in 2015/16 was £4,800,000 and the Trust achieved 88% of the value.

4.6 Care Quality Commission Registration

The Care Quality Commission (CQC) is the organisation that regulates and inspects health and social care services in England. All NHS hospitals are required to be registered with CQC in order to provide services and are required to maintain specified 'essential standards' in order to retain their registration.

As part of its role the CQC is required to monitor the quality of services provided across the NHS and to take action where standards fall short of the essential standards. Their assessment of quality is based on a range of diverse sources of external information about each Trust that is regularly updated and reviewed. This is in addition to their own observations during periodic, planned and unannounced inspections. If an issue raises concern during the data review process or from other sources of information, CQC may undertake an unplanned, responsive inspection.

The Luton and Dunstable University Hospital NHS Foundation Trust is fully registered with the CQC and its current registration is Registration without Conditions.

No enforcement action has been taken against the Trust during the reporting period April 1st 2015 and 31st March 2016 and we have not participated in special reviews or investigations by the CQC during the reporting period.

CQC Assessments

The CQC monitor, inspect and regulate care services to ensure patients receive safe, effective, compassionate, high quality care. To really measure the patient's experience of care, they have identified five key questions based on the things that matter to patients. The CQC will ask these questions of every service.

- **Are they safe?** By safe we mean people are protected from physical, psychological or emotional harm. For example are people getting MRSA because of poor hygiene?

- **Are they effective?** By effective we mean that people's needs are met and their care is in line with nationally recognised guidelines and relevant NICE quality standards or effective new techniques are used to give them the best chance of getting better. For example is there an effective 'enhanced recovery' programme?

- **Are they caring?** By caring we mean that people are treated with compassion, respect and dignity and that care is tailored to their needs.

- **Are they responsive to people's needs?** By responsive we mean that people get the treatment and care at the right time without excessive delay.

- **Are they well-led?** By well led we mean that there is effective leadership, governance (clinical and corporate) and clinical involvement at all levels of the organisation and an open, fair and transparent culture that listens and learns and that there is a clear programme of improvement.

The Care Quality Commission's team of inspectors visited the hospital over three days in January 2016 and carried out two further unannounced inspections to formally inspect and assess the quality of the care the trust provides. We are expecting the report in May 2016.

We have in place a CQC self assessment programme for all wards and clinical areas. This involves a three month cycle of self assessment, peer assessment and external peer assessment to support the delivery of performance and the implementation of corrective action in a timely manner. We have reviewed our CQC assessment programme to reflect the revised CQC inspections and these assessments are reported to each Board of Directors meeting.

Non-Executive Assessments (3x3)
The assessment process is further enhanced by Executive and Non-Executive Directors participating in our 3 x 3 initiative. The 3 x 3 initiative requires them to spend 3 hours every 3 months in a clinical setting working with staff to review their performance against CQC standards.

Transforming Quality Leadership 'Buddy' System
During 2015, we implemented a programme of quality reviews with the leadership team to assess quality across the Trust services. Leaders within the organisation were assigned a 'buddy' area and were required to complete weekly visits and escalate any issues. This process provided board to ward reviews and also supported staff to raise concerns and issues to the management team. This programme has developed into a revised quality monitoring framework.

4.7 Statements on Relevance of Data Quality and Action to Improve Data Quality

The accuracy and completeness of the data we use to support the delivery of high quality care is of the utmost importance to the Trust.

The Trust has been making progress with data quality during the year 2015/16. There are many processes carried out by the Information Team, which identify data quality issues.

Listed below are a few of the processes that are either carried out on a routine or adhoc basis by the Department:

- CCG challenges
- Monthly and weekly data quality reports sent out to users e.g. attendance not specified
- Theatre reports
- Benchmarking analysis – SUS dashboards
- Data Accuracy checks
- Completeness and Validity checks
- A&E not known GP checks
- A&E 0 wait arrival – departure times

During 2015/16 we have taken the following actions to improve data quality:

- Employed a full time Senior Data Quality Analyst
- Continued our extensive programme of data quality checks and initiatives involving staff and managers at all levels
- Added additional Data Quality Procedures to improve on areas e.g. ZZ postcodes, Choose from Dropdown Menu Referrals, No Health Authorities attached to patients
- Used automated reporting to increase the visibility of any data quality problems and expanded our contacts within the departments
- Continued to work with Commissioners to monitor and improve data quality pro actively in key areas.

NHS Code and General Medical Practice Code Validity

Luton and Dunstable University Hospital NHS Foundation Trust submitted records during 2015/16 to the Secondary Uses Service (SUS) for inclusion in the Hospital Episode Statistics which are included in the latest published data.

The percentage of records in the published data that included the patient's valid NHS number was:

- 99.5% for admitted patient care; 99.8% for outpatient care and 96.2% for A&E care.

The percentage of records in the published data which included the patient's valid General Medical Practice was:

100% for admitted patient care; 100% for outpatient care and 100% for A&E
- care

Action Plan for Data Quality Improvement for 2016/17

CCGs Challenges
1. Continue to work with Outpatients, IT & Divisions to improve other areas of known data issues (e.g. Elective Admissions and their decision to admit dates)
2. Continue to communicate with users the importance of recording the current GP at time of attendance or admission.
3. Continue to improve the NHS Number coverage
4. Continue to monitor Multiple Firsts

Attendance not specified
1. Continue to produce weekly and monthly lists identifying those patients with an attendance status of 'not specified'. Also work with the Outpatients, IT and Divisions to reiterate the importance and financial impact
2. Continue Outpatient Data Quality meetings.

Theatres
1. Increase the frequency of DQ Theatres reports from monthly to weekly to give staff more manageable numbers.

SUS dashboards
1. Work with Divisions to improve the completeness of the fields where the National Average is not being met (e.g. Paediatric HDU to improve PCCP data entry – slowly improving)
2. Use the dashboard to identify areas that require improvement (e.g. Ethnic Group Collection in Outpatients)

Data Quality Accuracy Checks
1. Maintain the number of audits on patient notes.

Completeness and validity checks
1. Remind staff about the importance of entering all relevant information as accurately as possible via Email and Liaising with IT Applications Training Team for individual ad hoc refresher training.

Other Data Quality meetings
The Information Team are working towards holding data quality meetings with A&E, Theatres, Inpatients and Maternity.

Clinical coding error rate
The Luton and Dunstable University Hospital NHS Foundation Trust was subject to an audit carried out by an established coding agency.

An error rate of 10% was reported for primary diagnosis coding (clinical coding) and 8.3% for primary procedure

coding. This demonstrates good performance when benchmarked nationally and achievement of level 2 attainment in the Information Governance Toolkit.

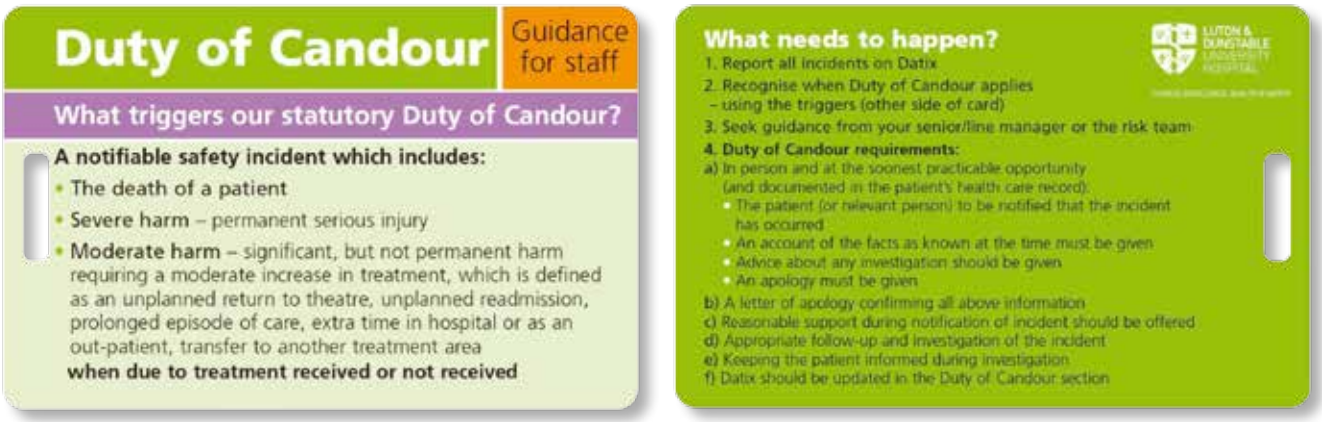
Information Governance toolkit attainment levels
The Luton and Dunstable University Hospital NHS Foundation Trust Information Governance Assessment report overall score for 2015/16 was 71% and was graded as Achieved – met at least level 2 on all standards. This is satisfactory (green).

The Information Quality and Records Management attainment levels assessed within the Information Governance Toolkit provides an overall measure of the quality of data systems, standards and processes within an organisation.

Duty of Candour (DoC)
The Trust has in place a Duty of Candour Policy that outlines the processes to undertake in relation to Being Open and DoC. The guidance incorporates the best practice for 'Being Open' issued from the NPSA and the DoC legislation November 2014.

Duty of Candour applies to notifiable safety incidents that are considered moderate harm, severe harm or the death of a patient. The Trust has agreed definitions that have been issued to staff as guidance (see figure 1 below). The policy outlines the actions that must be taken to comply with DoC.

Figure 1



The application of the DoC is monitored through the Clinical Operational Board through the incident reporting reports and assurance provided to the Clinical Outcome, Safety and Quality Committee.

Sign Up to Safety
Sign up to Safety is a National patient safety campaign that was announced in March 2014 by the Secretary of State for Health. It was launched on 24 June 2014 with the mission to strengthen patient safety in the NHS and make it the safest healthcare system in the world.
The Secretary of State for Health set out the ambition of halving avoidable harm in the NHS over the next three years, and saving 6,000 lives as a result. This is supported by a campaign that aims to listen to patients, carers and staff, learn from what they say when things go wrong and take action to improve patient's safety helping to ensure patients get harm free care every time, everywhere.

Organisations who Sign up to Safety commit to strengthen patient safety by:

- Setting out the actions they will undertake in response to the five Sign up to Safety pledges and agree to publish this on their website for staff, patients and the public to see.
- Committing to turn their actions into a safety improvement plan (including a driver diagram) which will show how organisations intend to save lives and reduce harm for patients over the next 3 years.

The five Sign up to Safety pledges are:

1. **Putting safety first.** Commit to reduce avoidable harm in the NHS by half and make public our locally developed goals and plans
2. **Continually learn.** Make our organisation more resilient to risks, by acting on the feedback from patients and staff and by constantly measuring and monitoring how safe our services are
3. **Being honest.** Be transparent with people about our progress to tackle patient safety issues and support staff to be candid with patients and their families if something goes wrong

4. **Collaborating.** Take a lead role in supporting local collaborative learning, so that improvements are made across all of the local services that patients use
5. **Being supportive.** Help people understand why things go wrong and how to put them right. Give staff the time and support to improve and celebrate progress.

The Sign up to Safety campaign is being led by Dr Suzette Woodward as Campaign Director. The campaign is not owned by any one NHS organisation; it is for everyone in every part of the NHS in England and is therefore working across the whole system. For administration and budget management support the Sign up to Safety team is being hosted by the NHS Litigation Authority, although they are not employees of this organisation. This is one example of the practical ways in which several national organisations have committed to system wide support of Sign up to Safety including:

- Monitor and the NHS Trust Development Authority are offering leadership and advice to trusts and foundation trusts who participate in Sign up to Safety and who will develop and own locally their improvement plans. They will also sign post to partner organisations for specific expertise where required.

- The Care Quality Commission will support trusts signed up by reviewing their improvement plans for safety as part of its inspection programme. CQC will not offer a judgment on the plans themselves but consider them as a key source of evidence for Trusts to demonstrate how they are meeting the expectations of the five domains of safety and quality.

- The Department of Health will provide Government-level support to the campaign and work with the Sign up to Safety partners to ensure that the policy framework does all it can to support the campaign and the development of a culture of safer care.

The L&D has signed up for safety in conjunction with the University College of London (UCL) Partners. UCL Partners is one of five accredited academic health science systems in the UK. The purpose of the role that UCL Partners play is to support the translation of cutting edge research, innovation and education into measurable health gain for patients and populations. It has a partnership with over 40 higher education and NHS members, and a central team providing operational support and clinical academic leadership. The UCL Partners has a central team based in London who collaborate with Health Care organisations across north east and north central London, south and west Hertfordshire, south Bedfordshire and south west and mid Essex providing opportunities for learning and sharing learning – holding and hosting events to facilitate this. Their intention is that organisations by working together, are able to implement improvements in healthcare at greater scale and pace.

In Mid 2014 UCL Partners consulted its partner organisations asking them to identify safety priorities. In a meeting held with the Director of Clinical Quality, of UCL Partners the following three clinical safety priorities were identified for L&D as the Sign up for Safety campaign:

1. Improving the management of the Deteriorating Patient
2. Improving the Management of patients presenting with Acute Kidney Injury (AKI)
3. Improving the Management of patients presenting with Sepsis

Acute Kidney Injury and Sepsis were identified as priorities by many other of UCL's Partner organisations, and also contribute to the greatest number of avoidable deaths (based on National Data). They therefore form part of the first two workstreams of the UCL Partners Patient Safety programme. The L&D have already been collaborating with the UCL Partners for the past three years are on Improving the Management of the Deteriorating patient – and has formally signed up with UCL Partners to both the AKI and the Sepsis workstreams, and key clinicians have attended the first collaborative events for these workstreams. They have also formed part of the Quality Account Quality Priorities since 2015.

Good engagement from medical, nursing staff and support staff is critical to support improvements in the clinical area. Three separate Steering groups have been set up for the three clinical priorities: improvement in the management of the deteriorating patient, patients presenting with AKI and Sepsis. The groups are assisting with setting priorities designing and steering the programmes. Key members of the steering groups have attended the UCL Partnership collaborative days and are actively supporting the incorporating the learning from the collaborative days into the improvement programmes. The Improvement programmes are used to coordinate and prioritise the workstream. The workstreams for the Sepsis and the AKI programmes commenced in September 2015 includes reviews on an ongoing basis on how we are meeting the requirements to the 5 safety pledges. Separate reports are provided on a quarterly basis, updating the Clinical Operational Board and providing assurance to the Clinical Outcome Safety and Quality Committee with the progress on the key objectivities and outcomes of each of the workstreams.

5. A Review of Quality Performance

Part 3

5.1 Progress 2014/15

A review of clinical indicators of quality

The table below shows progress in the patient safety, patient experience and clinical effectiveness indicators selected by our stakeholders. These indicators were selected in 2009/10 through a survey and the most popular indicators were selected. We have continued to follow the selected data sets and any amendments have been described below the table.

Performance Indicator	Type of Indicator and Source of data	2012* or 2012/13	2013* or 2013/14	2014* or 2014/15	2015* or 2015/16	National Average	What does this mean?
Number of hospital acquired MRSA Bacteraemia cases (n)	Patient Safety Trust Board Reports (DH criteria)	2	3	3 ***	1	N/A	The Trust has a zero tolerance for MRSA. During 15/16 there was an isolated case.
Hospital Standardised Mortality Ratio* (n)	Patient Safety Dr Foster / Trust Board Report	97.2*	96*	106*	112*	100	The HSMR indicators are monitored. This is subject to on-going review by the Mortality Board.
Number of hospital acquired C.Difficile cases (n)	Patient Safety Trust Board Reports	17	19	10	11	N/A	Demonstrating an stable position. Remains one of the lowest in the country
Incidence of hospital acquired grade 3 or 4 pressure ulcers	Patient Safety Trust Board Report	51**	30	19	11	N/A	Demonstrating an improving position.
Number of Central line infections < 30 days (Adults)	Patient Safety Trust Internal Report	4	4	3	2	N/A	Demonstrating an improving position.
Cardiac arrest rate per 1000 discharges	Patient Safety Trust Board Report	1.8	1.6	1.6	1.04	N/A	Maintaining good performance.
Average LOS (excluding healthy babies)	Clinical Effectiveness Trust Patient Administration Information Systems	3.7 days	3.6 days	3.4 days	3.2 days	N/A	Demonstrating an improving position in line with the Trust plans.

Performance Indicator	Type of Indicator and Source of data	2012* or 2012/13	2013* or 2013/14	2014* or 2014/15	2015* or 2015/16	National Average	What does this mean?
Rate of falls per 1000 bed days	Clinical Effectiveness Trust Board Report	5.5	4.87	4.25	4.32	5.5	Maintaining performance.
% of stroke patients spending 90% of their inpatient stay on the stroke unit (n)	Clinical Effectiveness	78.3%	84.7%	79.5%	69.4%	Target of 80%	This has continued to be a challenge and the Trust has a robust action plan in place to improve performance.
% of fractured neck of femur to theatre in 36hrs (n)	Clinical Effectiveness Dr Foster	80%	82%	75%	78%	N/A	There has been an improvement in the performance
In-hospital mortality (HSMR) for acute myocardial infarction (heart attack) (n)	Clinical Effectiveness Dr Foster	52.5*	76*	79*	69.7*	100	This is demonstrating the Trust as a positive outlier and improved performance on the previous year.
In-hospital mortality (HSMR) for Acute Cerebrovascular Accident (stroke) (n)	Clinical Effectiveness Dr Foster	87.7*	91*	109*	112.8*	100	The HSMR indicators are monitored. This is subject to on-going review by the Mortality Board.
Readmission rates*: Knee Replacements Trauma and Orthopaedics (n)	Clinical Effectiveness Dr Foster	11.4%	4.7%	6.7%	7.2%	N/A	There has been a slight increase. A review of Trust data has been undertaken and no concerns were identified.
% Caesarean Section rates	Patient Experience Obstetric dashboard	25.5%	25.7%	27.8%	28.3%	25%	The Trust is a level 3 NICU and received high risk patient transfers
Patients who felt that they were treated with respect and dignity**	Patient Experience National in patient survey response	8.7	9.0	8.9	9.0	Range 8.5 - 9.7	Demonstrating an improving position
Complaints rate per 1000 discharges (in patients)	Patient Experience Complaints database and Dr Foster number of spells for the year	3.62	7.01	7.12	6.29	N/A	The Trust continues to encourage patients to complain to enable learning.

Performance Indicator	Type of Indicator and Source of data	2012* or 2012/13	2013* or 2013/14	2014* or 2014/15	2015* or 2015/16	National Average	What does this mean?
% patients disturbed at night by staff (n)	Patient Experience CQC Patient Survey	8.0	7.9	7.8	7.4	Range 7.0 – 9.3	Demonstrating a slightly poorer position but still within range.
Venous thromboemolism risk assessment	Patient Experience Commissioning for Quality National Goal since 2011	Achieved >95% all year	Achieved >95% all year	Achieved >95% all year	Achieved >95% all year	N/A	Maintaining a good performance.

(n) Denotes that this is data governed by standard national definitions

* Denotes calendar year
** Patients who felt that they were treated with respect and dignity is now reported in place of % patients who would rate the service as excellent, very good or good (in-patients). This is no longer asked within the national annual in-patient survey.
*** Public Health England Healthcare Acquired Infection

Surveillance Group identifies the number of MRSA bacteraemia "allocated" to the Trust as 4. However, although the Trust has learned from this case, this bacteraemia was identified in A&E, was classed as a contaminant and is therefore a community acquired bacteraemia. The Trust has maintained low rates of MRSA throughout 2014/15 but was above the set ceiling of 0. The Trust conducts root cause analysis to identify learning from each incident.

5.2 Major quality improvement achievements within 2015/16

The Trust Quality Priorities are identified and reported in detail within the Quality Account.

Improving Quality

The Trust Quality Priorities are identified and reported in detail within the Quality Account.

Mortality and Complaints Boards
The Mortality Board and Complaints Board continued throughout 2015/16. Both meetings are chaired by the Chief Executive Officer (CEO) and have wide representation from divisions and also include Non-Executive Directors.

The Trust Mortality Board managed an action plan and:
- Completed detailed case reviews of areas of concern
- Initiated on-going reviews of all patient deaths
- Arranged for an external review of our response to the elevated HSMR.

To date no major clinical issue has been identified, although a series of service changes are planned, some of which are already implemented to further improve the overall quality of care patients receive.

The Complaints Board continues to see improvements in the management of complaints by the Divisions. The divisions have continued to implement changes to the governance of complaints to manage the process and implement any learning.

Raising Concerns and Freedom to Speak Up Guardian
We have continued our focus on encouraging our staff to raise any concerns. During July 2015, the CEO followed up an initial letter she had sent in January 2015, and wrote to all staff asking them to tell her (confidentially) if they believe a patient has suffered harm or if there has been a near miss and they do not feel confident that the incident is being properly addressed.

National guidance has also been received that requires us to have a 'Freedom to Speak Up Guardian Role' that we need to have in place by the end of March 2017 and work began to develop proposals for implementation.

Engagement Events – 'Good Better Best'
At the heart of L&D is a culture of staff ownership and involvement. This culture is nurtured by a comprehensive range of communication and engagement activities. Particularly important was the large scale, trust wide 'Good, Better, Best' events where all staff came together to identify quality priorities and monitor progress in

improving clinical outcome, patient safety and patient experience. The events also provided the opportunity to feedback learning from serious incidents and any action taken as a result of issues raised. It is planned to continue these events throughout 2016/17.

Compliance Manager
During 2015, we developed a key organisational role of 'Compliance Manager'. This role was pivotal to our on-going assessment of quality across the Trust in line with the CQC Core Standards and Key Lines of Enquiry. The role will continue to monitor compliance and ensure that we further develop systems and processes in order to maintain, further develop and enhance quality.

Transforming Quality Leadership 'Buddy' System
Building on the Compliance Manager role, we implemented a programme of quality reviews with the leadership team was implemented to assess quality across the Trust services. Leaders within the organisation were assigned a 'buddy' area and were required to complete weekly visits and escalate any issues. This process provided 'board to ward' reviews and also supported staff to raise concerns and issues to the management team. It also supported a key part of the Trust preparation for the CQC inspection. This programme has developed into a revised quality monitoring framework.

Revised On-going Compliance and Quality Monitoring framework
In March 2016, the Clinical Outcome Safety and Quality Committee agreed a revised On-going Compliance and Quality Monitoring framework.

We will implement an improved co-ordinated monitoring framework which is linked to the fundamental standards of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.

The components of the framework are already in place within the Trust, but the framework outlines how the following will be co-ordinated:

- Senior Manager Buddy link to clinical areas /checklist
- Peer Review Programme (both internal and external)
- Nursing and Midwifery quality and safety indicators (Harm Free Care / Nurse Sensitive Indicators / Safety Thermometer)
- Patient-Led Assessments of the Care Environment (PLACE)
- Friends & Family Test
- Non-Executive Directors walk round
- Patient Surveys (internal and external)
- Staff satisfaction surveys (externally led)
- Staff Appraisals
- Staff 1:1s
- Incident reports / Number of Serious Incidents
- Annual Full Inspection

The introduction of an annual CQC style **'Full Inspection'** of all wards and registered locations of the Trust will be conducted over the period of a week, using subject experts from all departments of the Trust (including cleaning and catering contractors). This inspection will result in each clinical area being awarded an annual rating to ensure that they are Safe, Effective, Caring, Responsive and Well Led. These ratings will be aligned to the CQC rating scale. (Outstanding, Good, Requires Improvement and Inadequate).

This will also be linked to a Nursing and Midwifery Ward Accreditation Award Scheme, which is currently being finalised. The programme will be on-going and will commence in April 2016, with our first 'Full Inspection' planned for October 2016.

We will use forums already accessible and committed to measuring the CQC standards which includes the annual PLACE inspection, Back to the Floor Friday (BTFF) as well as the information from audits undertaken on both a regular and ad hoc basis.

We will relaunch the internal Peer Review Programme implementing a new framework linked to the CQC's Key Lines of Enquiry (KLOEs) which will enable the reviewers to award a percentage aligned to a RAG rating. There will be a consistent approach throughout the Peer Reviewing Programme, all answers/evidence /observations on the framework measurable, we are currently developing a scoring system which will enable a final percentage score to be calculated and subsequently aligned to a rating category to each domain. Simple guidance, for the monitoring tool and the scoring system will be produced for all 'reviewers'.

We continually look to share best practice with others and we engage with other NHS organisations inviting them to visit the Trust once every six months.

5.3 Friends and Family Test

The Friends and Family Test (FFT) is a national initiative that gives patients the opportunity to provide us with real time feedback about their experience of our services. It gives the Trust the opportunity to rectify problems quickly. Information is analysed to identify recurring themes at ward or departmental level, as well as issues that appear to affect services across the whole Trust.
FFT was first introduced at the L&D during 2012/13,

seeking feedback from adults who had been inpatients. This was extended to both the Accident and Emergency Department and Maternity Services, followed by inclusion of patients who had received Day Case procedures and those who had been seen in Outpatients. Since April 2015 FFT has been implemented across the entire Trust and reported nationally each month with the aim of ensuring that all our patients are given the opportunity to identify whether or not they would recommend our service to their friends or family.

At the L&D, the FFT feedback is collected in a variety of ways: on paper forms; online through the hospital website and through telephone calls made to patients by staff from our Patient Experience Call Centre. The call centre staff gather information 48 hours after patients are discharged using a semi-structured survey approach, and which includes the FFT question.

The FFT question posed to patients is:
How likely are you to recommend our ward to friends and family if they needed similar care or treatment?

The question is adapted slightly for children's areas and an easy read version is available if required. There are free text boxes on the form providing patients with the opportunity to leave comments.

A quarterly report of the patient experience feedback is reviewed at the Clinical Outcomes, Safety and Quality Committee and by the Patient and Public Participation Group. Results are reported monthly to NHS England and locally on the Trust website and NHS Choices.

Tables 1-4 show the percentage recommend scores across all areas of the Trust. These statistics are reported monthly to NHS England.

2015/16 has seen a decline in the response rates for FFT. In March 2016 the Trust achieved a response rate of 18.4% for inpatients, 1.5% for A&E and 28.7% for Maternity. In response to the lower response rates in A&E, the Trust implemented a number of actions to improve:

- Introduction of a link on Ipads for access to the FFT on wards.
- Monthly updates for wards and areas providing the number of cards/responses to collect to achieve a 40% response rate for wards and 20% for Emergency Department.
- Updates in staff brief
- Accident and Emergency Department have plans to implement text messaging patients to gain feedback on the services which should improve the response rate.

Table 1 Inpatients Percentage Recommend Scores 2015/16

Comparison of Inpatient Percentage Recommend Scores Q1 2015/16 to Q4 2015/16 (includes Daycases)

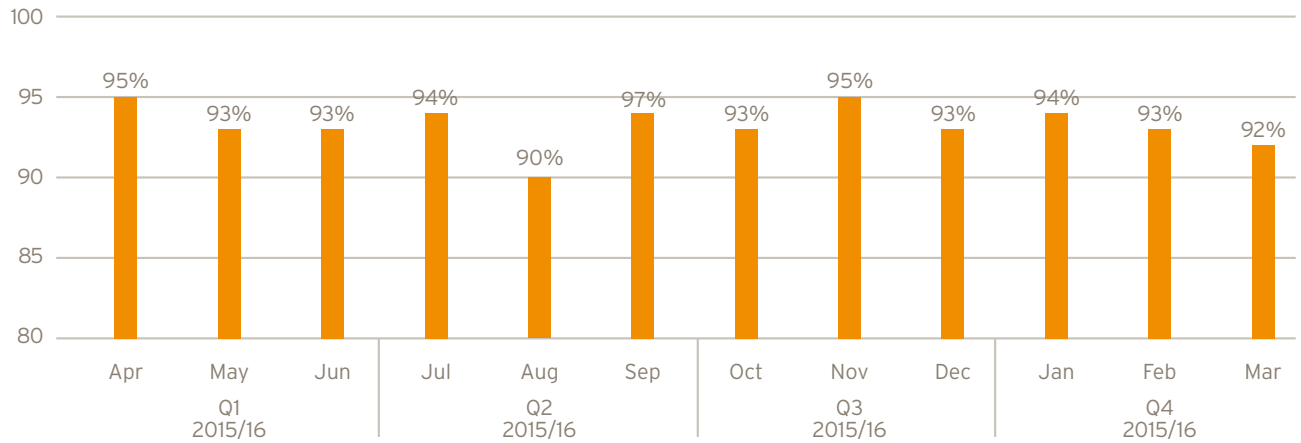


Table 2 Accident and Emergency Percentage Recommend Scores 2015/16

Comparison of Accident and Emergency Percentage Recommend Scores Q1 2015/16 and Q32015/16

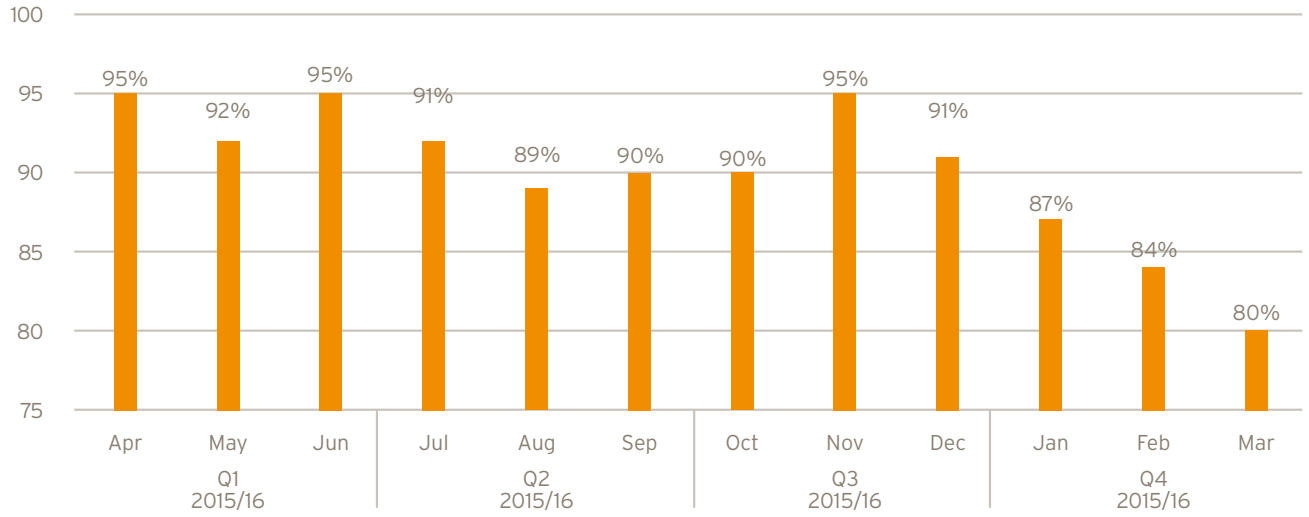


Table 3 Maternity Percentage Recommend Scores 2015/16

Comparison of Overall Maternity Percentage Recommend Scores Q1 2015/16 and Q3 2015/16

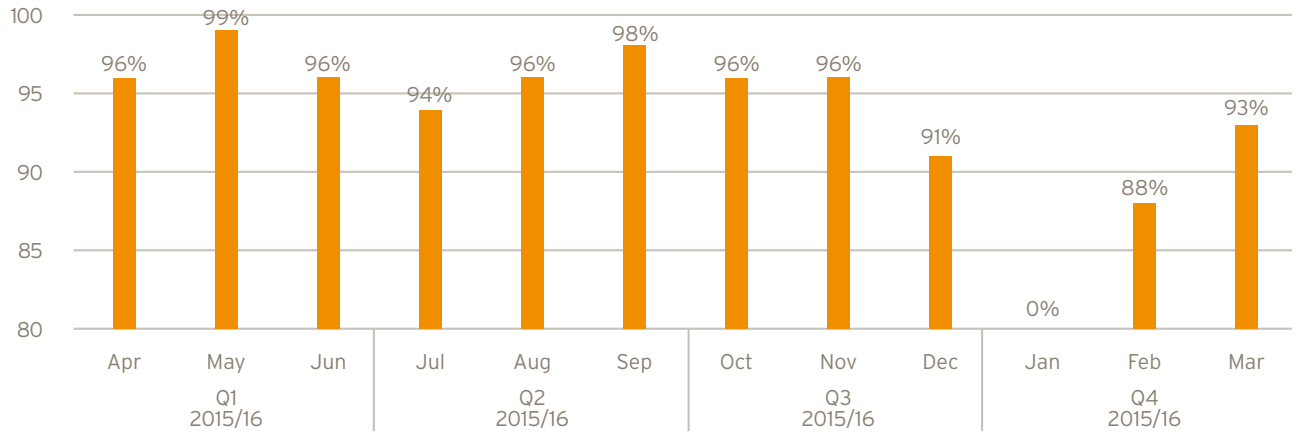
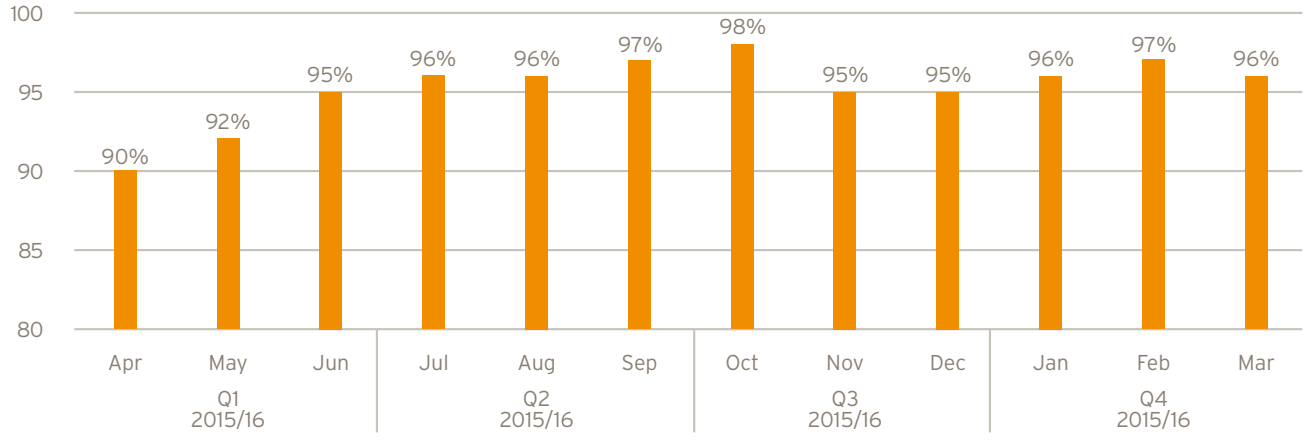


Table 4 Outpatients Percentage Recommend Scores 2015/16

Comparison of Outpatient Percentage Recommend Scores Q412015/16 and Q3 2015/16



The following are examples of action taken in response to feedback about individual wards:

- Improved structure of ward rounds due to feedback that communication could be improved.
- One ward has reduced noise at night by closing the doors to the bays and aiming to complete transfers to other wards by 11pm.
- Paediatrics have developed a communication sheet for each child's file. This gives a clear outline of the care plans for the child which can be communicated by any member of staff. This will help us to ensure that all communication is consistent.

Wards use the Quality and Safety Information Boards to report on the FFT recommend score and to display 'You Said/We Did' information for their patients to see. This information is updated monthly.

National Inpatient Survey 2015

The report of the L&D inpatient survey was received on the 25th May 2016 and the results detailed in the table below are published by the Care Quality Commission. Detailed management reports are shared internally and action plans developed by divisions and reviewed and monitored at Clinical Outcomes, Safety and Quality meetings. Patients who were treated in July 2015 were surveyed. 553 patients responded, representing a response rate of 46% compared to 41% last year.

Results of the national in-patient survey 2015

Category	2011	2012	2013	2014	2015	Trust year on year comparison	Comparison other NHS hospitals
The emergency / A&E department, answered by emergency patients only	7.1	8.4	8.4	8.2	8.6	Increased	The same
Waiting lists and planned admission, answered by those referred to hospital	6.3	9.0	9.1	8.9	8.8	Decreased	The same
Waiting to get to a bed on a ward	6.6	7.0	6.5	7.1	7.3	Increased	The same
The hospital and ward	7.8	8.1	8.1	8.0	8.0	No change	The same
Doctors	7.9	8.2	8.4	8.4	8.3	Decreasing	The same
Nurses	7.9	8.1	8.2	8.1	8.3	Increasing	The same
Care and treatment	7.1	7.5	7.6	7.6	7.7	Increasing	The same
Operations and procedures, answered by patients who had an operation or procedure	8.3	8.3	8.2	8.4	8.4	No change	The same
Leaving hospital	6.8	7.0	7.1	6.8	6.8	No change	The same
Overall views and experiences	6.0	5.5	5.5	5.5	5.3	Decreasing	The same

Note all scores out of 10

Hospital and Ward category asks questions about cleanliness, hospital food and sleeping areas. The category Doctors and Nurses includes questions on confidence and understanding staff and Care and Treatment covers privacy, information on treatment and decisions about care.

Patient Stories and improvements following patient feedback.

A 63 year old lady was admitted to one of the surgical wards for a left knee replacement, she had some twelve weeks ago undergone an identical procedure to her right knee. The patients experience had been very positive when she had her right knee surgery and she felt prepared for surgery on this occasion.

Surgery went as planned; she was very satisfied with the multi professional care which she received. Her immediate post-operative recovery was as anticipated, she began mobilising with crutches and as time passed she became more confident. She was seen by the physio who was pleased with her progress and was happy to support her discharge once her consultant had declared her as medically fit. The ward round took place later in the morning and she was duly discharged by the consultant. As the lady lived alone she had arranged for family members to come and stay for the initial few days to support her upon discharge. It was agreed that she could go home later in the afternoon so she arranged to be collected early evening, the nursing and medical staff then proceeded to make the appropriate arrangements to facilitate discharge.

At 18.00 hours she was duly packed and ready to leave the hospital, her 'transport' had arrived and all she required was her discharge letter and TTAs. She waited and waited and by 21.00 these had still not arrived, feeling frustrated and upon speaking with the nursing staff her TTAs could not be located, so upon agreement with the team she would go home and a family member would collect her TTAs in the morning. She finally left the hospital at 21.30 hours, by which time her pain management had been lost as she had not received required analgesia.

The following morning, her family member came into the ward to collect her drugs, expecting them to be awaiting his arrival he found himself waiting a further hour for them to be delivered to the ward.

Although the lady continues to make a good recovery she openly describes how one negative experience can make an experience which was very positive be very quickly forgotten. She is very keen for the ward staff and MDT to learn from her story and to ensure that no one else has the same experience.

We recognise the importance of carers to our patients. Part of our improvement work involves feedback from the carer's for people with Dementia during their hospital stay. As a result of some of the feedback from last year we have implemented some improvements to the care we deliver for our patients and their carers.

"Staff need to understand and know my mum has dementia & how it affects her" – We introduced a discrete alert symbol to our medical notes, staff communication boards and identification bands to alert staff and enable them to adapt their approach to care for the individual. A 'This is me' biography is also offered to the carer to complete on admission to facilitate more person centred approach to care.

"Carers need to be involved and updated at all times"– we now offer extended visiting to all carers of people with Dementia. This allows us to build a partnership in care for the good of the patient. Extending the visiting also allows the carer more time with the patient providing a familiar face during an anxious time. It also allows the carer more access and time to become involved in the care should they wish to and discussions with the medical and nursing teams. A proposal has been forwarded to the board to launch a national campaign 'John's Campaign' within the Trust, which advocates the rights of a carer.

" Mum gets bored and needs to be kept stimulated" - we have purchased distraction equipment/boxes for most of the in-patient ward areas. This provides activities such as; cards, dominoes, picture scrap books, music, knitting, puzzles, reminiscence. The boxes are available for staff/volunteers and carers to utilise with the person with Dementia. A funding application and proposal for an 'activities coordinator' has been made to provide stimulating activities to groups of inpatients to promote wellbeing and social stimulation.

Our patients have told is that there was nowhere on the ground floor of the surgical block to sit, either when waiting for the lift or generally to sit and converse with others. In response to this feedback two large couches were purchased to provide a seating facility for patients or their significant others. Although the couches have only been 'in situ' for two weeks and no formal feedback has been received – it is pleasing to see the frequency that these are used throughout the day and into the evening.

One of our patients has early onset inflammatory bowel disease. Since the age of 2 years she has needed frequent blood tests and cannula insertions. Despite involving play specialists, and using numbing cream, the child became increasingly distressed at cannulation. On one occasion she was observed running down the corridor in a very distressed state, trying to get away from the cannula.

We looked at what else may be available to help her (she was still too young to benefit from clinical psychology). We bought a Buzzy (drug free pain relief) device and trained the staff on ward 26 to use it. This transformed her experience. She now has injections at home, using her own Buzzy device, that her parents say "is part of the family".

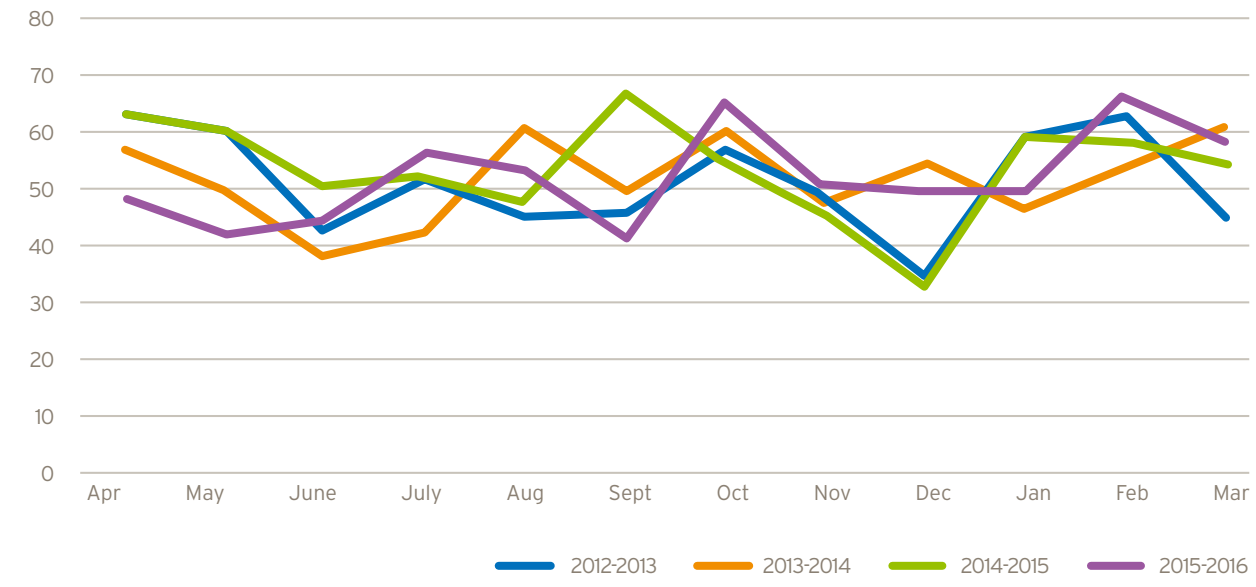
Since then, we have purchased an additional Buzzy for use in children's outpatients. We developed a clinical guideline to support its use. One of our newly appointed band 6 sisters is planning to champion use of Buzzy so that it is used more widely. Several other children have purchased devices so that they can use them across care settings.

5.5 Complaints

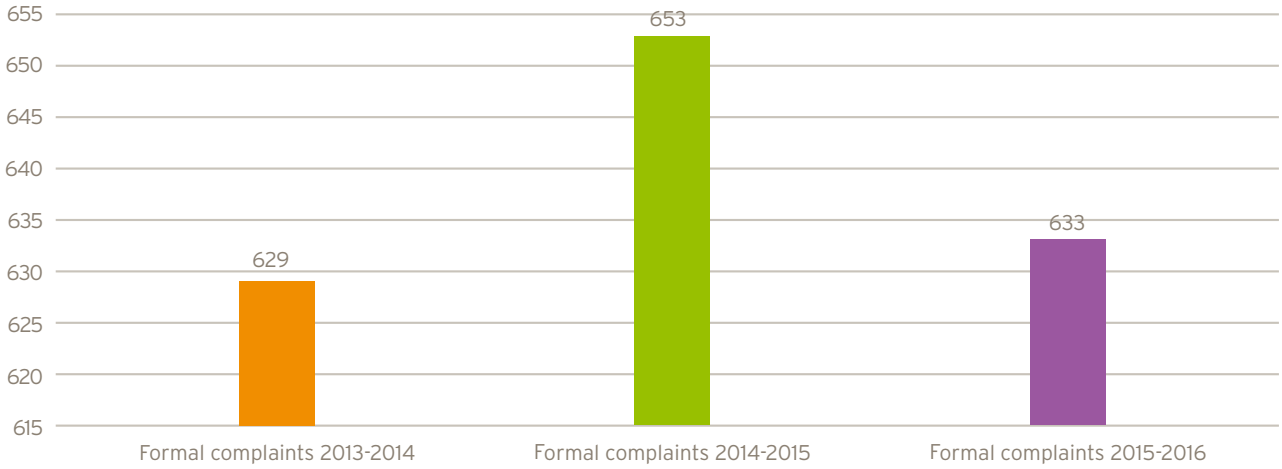
In 2015/16 the Trust has continued to welcome patient feedback. Following review of the Complaints and Concerns Policy, there has been a continuing focus to ensure that we efficiently answer complaints and concerns in a timely manner and continually use this information to improve our services.

During 2015/16 we received 633 formal complaints compared to 653 in 2014/15. The breakdown shows a decrease in the number of formal complaints received at the Trust since the last financial year. Whilst complaints have remained static with no significant increase or decrease it is recognised that there is a heightened public awareness of the option to complain. The Trust has made significant effort to resolve people's concerns quickly, reducing the need for them to follow the formal complaints process.

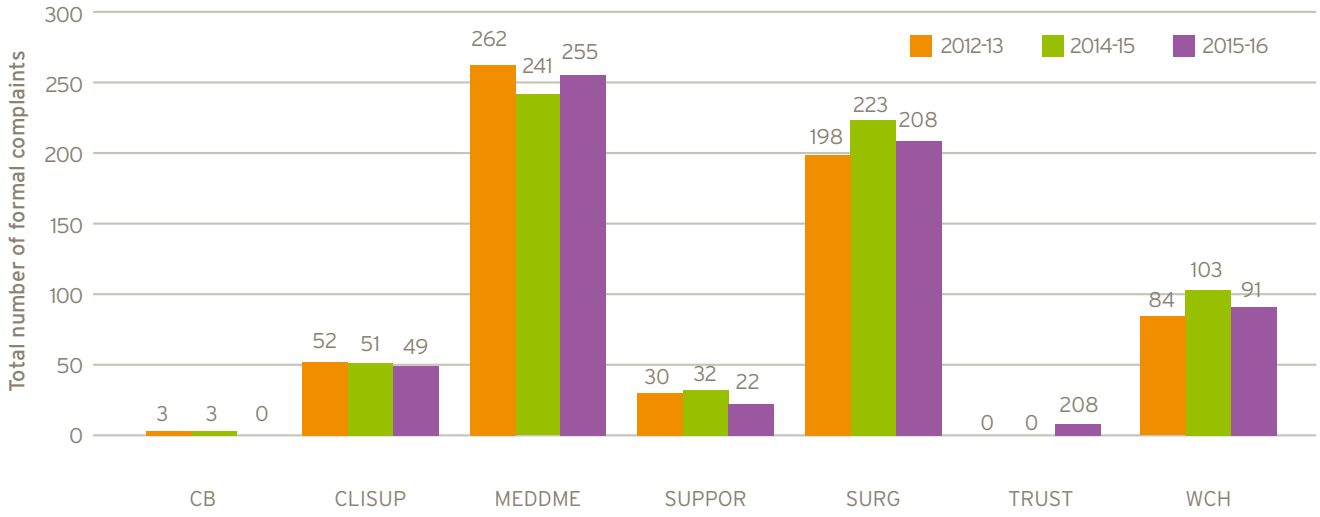
Formal Complaints



Formal Complaints



Complaints by division



Learning from Complaints

As part of the complaints process, learning is identified through an action plan that is monitored by the Divisions and assurance provided to the Complaints Board. Some examples of learning during 2015/16 are:

- The process for the availability of pressure relieving mattresses was amended to ensure that there are no gaps in provision
- In the Emergency Department, the teaching programmes were enhanced to remind clinical staff to take into account parental concern as well as the clinical examination.
- We instigated further ward checks for patient transfers to ensure that the families and next of kin are informed in a more timely manner.
- Training is being provided on staff study day to make staff more aware the challenges patients with disabilities and learning difficulties face. Also a review of work instructions for screening of patients with a learning disability to make it reflect the important role carers have and to ensure they can accompany ladies into the x-ray room was undertaken.

Listening to Patient Concerns

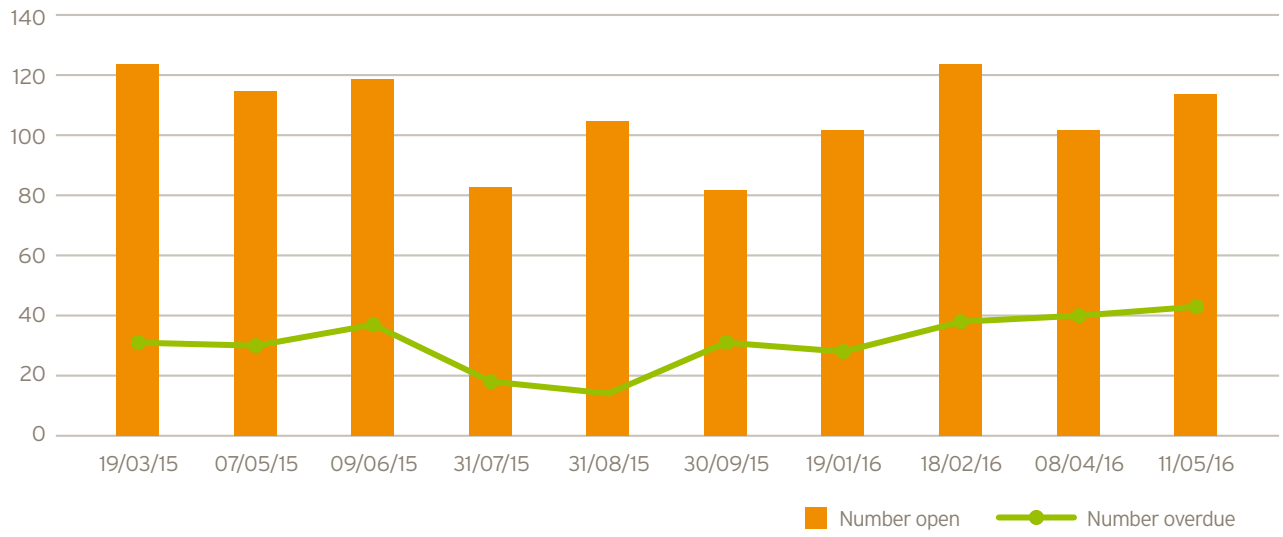
We treat all complaints seriously and ensure they are handled in accordance with the Health and Social Care Complaints Regulations. During the reporting period we received 595 formal complaints. A breakdown of complaints (by month, by category is contained within the Quality Account.

All the complaints were thoroughly investigated by the General Manager for the appropriate division involved and a full and honest report was sent to the complainant.

The majority of complainants were resolved at local resolution level. Some of the meetings were headed by the General Managers and some meetings were with the Medical Director or the CEO. However, 12 complainants asked the Parliamentary and Health Service Ombudsman (PHSO) to review their complaints. Following this process, five complaints have been investigated and a final report has been done, two are waiting for a decision' and five are being investigated by the Ombudsman.

The data collated throughout the year highlights that there is further action that needs to undertaken to improve consistency of achieving the timescales for responding to complaints. However, the quality of the investigations being carried out and the standard of those responses remain very high and the percentage of the re-opened complaints where the complainant feels that their complaints has not been responded to fell from 6.53% in 2014/15 to 6.33% in 2015/16.

Number open (March 2015 to 8 April 2016 v Number Overdue as at 11 May 2016)



We have made improvements to our complaints process, for example:

- If people are not happy with their response they are invited to come for a Local Resolution Meeting to discuss their concerns.

We are sending our questionnaires with all our responses for patient feed -back.

- Patient Affairs completes a weekly update and this includes the overdue complaints for every division and therefore this is escalated to senior managers.

Compliments

During the reporting period over approximately 6,500 compliments were received directly by the staff or service, and cascaded to the staff and/or service involved by the respective manager. This is an increase of 1,500 from the previous year. Below are some of the compliments we received recently:

"I came to A&E on Sunday morning 21st February 2016 with chest pains.

From the moment we arrived we were treated fantastic by superb staff who all acted calm and professional which straight away calmed me down and put me at ease I was seen very quickly and given a full check- up. The doctor and nurse who cared for me were first class can you pass on my thanks to them unfortunately I cannot remember their names I think the staff do a fantastic job."

"I would like to thank you for the kind and caring treatment I received at the breast screening unit."

"My son has recently been in for an operation and I wanted to say a massive thank you to the staff in the hedgehog ward on the 8/02/2016 and all the staff who looked after him in the ground floor theatre. I can't put into words how amazing everyone was on that day with me being a nervous wreck. Thank you all so much."

"I visited the A&E dept today after having a coughing episode and passing out and damaging rib tissue. I would like to commend the Triage nurse and two doctors who examined and treated me. They were friendly, extremely efficient and a credit to your hospital and the NHS. I hope my thanks can be passed on to the dept."

"I would just like to say that I went into hospital on the 22/12/15 for a hysterectomy. He [the consultant] did a fantastic job and the nurses on ward 34 were great! I had barely any pain afterwards and am so happy I went through the procedure. Many thanks for all that your staff did for me."

"I have just had to stay on ward 21 for two nights and the care was first class a hard working team that were kind compassionate and professional. Restored my faith in the NHS."

"[The patient] was admitted to your hospital in November 2015 and died on ward 14 on the 15th November. I wanted to thank all the staff on this ward for the incredible care and compassion they showed to him in his last weeks. It was a great help for those of us who loved him to know he was in such good hands. We knew he wouldn't be allowed to suffer or feel uncomfortable. All the staff were first class - genuinely caring and highly competent. The cleaning staff worked so hard and were also so friendly and interested in how we were doing. We were all so impressed with everyone connected with this ward; I do hope you will pass on this email to them. We won't forget what they did."

5.6 Performance against Key National Priorities 2015/16

		2012/13	2013/14	2014/15	2015/16	Target 15/16
Target 1: Clostridium Difficile	To achieve contracted level of no more than 19 cases per annum (hospital acquired)	17	19	10	11	6
Target 2: MRSA	To achieve contracted level of 0 cases per annum	2	3	3*	1	0
Target 3: Cancer	Maximum waiting time of 31 days from decision to treat to treatment start for all cancers	99.6%	99.8%	100%	100%	96%
Target 4: Cancer	Maximum waiting time of 62 days from all referrals to treatment for all cancers	90.3%	91.5%	91%	88.4%	85%
Target 5: Cancer	Maximum waiting time of 2 weeks from urgent GP referrals to first outpatient appointment	95.6%	95.7%	95.5%	95.8%	93%
Target 6: Cancer	Maximum waiting time of 31 days for second or subsequent treatment					
	Surgery	98.9%	100%	98.9%	98.6%	94%
	Anti-cancer Drugs	99.8%	100%	100%	99.8%	98%
Target 7: Patient Waiting Times	Referral to treatment -percentage treatment within 18 weeks - admitted	Target achieved in all 12 months of the year	93.6%	94.1%	92.9%	90%
Target 8: Patient Waiting Times	Referral to treatment -percentage treatment within 18 weeks - non admitted	Target achieved in all 12 months of the year	97.1%	96.8%	97%	95%

		2012/13	2013/14	2014/15	2015/16	Target 15/16
Target 9: Patient Waiting Times	Referral to treatment -percentage patients waiting so far within 18 weeks - incomplete pathways	Target achieved in all 12 months of the year	96.5%	96.9%	96.3%	92%
Target 10: Accident and Emergency	Maximum waiting time of 4 hours in A & E from arrival to admission	98.5%	98.4	98.6%	98.6%	95%
Target 11: Learning Disability	Compliance with requirements regarding access to healthcare for people with a learning disability	Achieved	Achieved	Achieved	Achieved	Achieved

* Public Health England Healthcare Acquired Infection Surveillance Group identifies the number of MRSA bacteraemia "allocated" to the Trust as 4. However, although the Trust has learned from this case, this bacteraemia was identified in A&E, was classed as a contaminant and is therefore a community acquired bacteraemia. The Trust has maintained low rates of MRSA throughout 2014/15 but was above the set ceiling of 0. The Trust conducts root cause analysis to identify learning from each incident.
** currently to February 2016 – March data to be added in May 2016

5.7 Performance against Core Indicators 2015/16

Indicator: Summary hospital-level mortality indicator ("SHMI")

SHMI is a hospital-level indicator which measures whether mortality associated with a stay in hospital was in line with expectations. SHMI is the ratio of observed deaths in a Trust over a period of time, divided by the expected number given the characteristics of patients treated by the Trust. SHMI is not an absolute measure of quality; however, it is a useful indicator to help Trusts understand mortality rates across every service provided during the reporting period. The L&D is a provider of level 3 Neo-natal care that cares for the most premature babies and it is acknowledged that SHMI does not adequately risk adjust for a level 3 NICU provided in a District General Hospital. Other benchmarking data is used to provide assurance on performance and data is also subject to on-going review. Trusts are advised to use the banding descriptions i.e. 'higher than expected', 'as expected', or 'lower than expected' rather than the numerical codes which correspond to these bandings

	Reporting period	L&D Score	National Average	Highest score (best)	Lowest score (worst)	Banding
Value and banding of the SHMI indicator	Published Apr 13 (Oct 11 -Sep 12)	As expected	As expected			2
	Published Jul 13 (Jan 12 - Dec 12)	As expected	As expected			2
	Published Oct 13 (Apr 12 -Mar 13)	As expected	As expected			2
	Published Jan 14 (Jul 12 – Jun 13)	As expected	As expected			2
	Published Oct 14 (Apr 13 -Mar 14)	As expected	As expected			2
	Published Jan 15 (Jul 13 – Jun 14)	As expected	As expected			2
	Published Mar 16 (Sep 14 -Sep 15)	As expected	As expected			2

	Reporting period	L&D Score	National Average	Highest score (best)	Lowest score (worst)	Banding
The percentage of patient deaths with palliative care coded at either diagnosis or speciality level (The palliative care indicator is a contextual indicator	Published Apr 13 (Oct 11 –Sep 12)	12.4%	19.2%	0.2%	43.3%	N/A
	Published Jul 13 (Jan 12 - Dec 12)	11.5%	19.5%	0.1%	42.7%	N/A
	Published Oct 13 (Apr 12 –Mar 13)	12.2%	20.4%	0.1%	44%	N/A
	Published Jan 14 (Jul 12 – Jun 13)	12.6%	20.6%	0%	44.1%	N/A
	Published Oct 14 (Apr 13 –Mar 14)	13.7%	23.9%	0%	48.5%	N/A
	Published Jan 15 (Jul 13 – Jun 14)	14.7%	24.8%	0%	49%	N/A
	Published Mar 16 (Sep 14 –Sep 15)	13.8%	26.7%	0%	53.5%	N/A

The Luton and Dunstable University Hospital considers that this data is as described for the following reason:
- This is based upon clinical coding and the Trust is audited annually.
- The Luton and Dunstable University Hospital intends to take the following actions to improve this score, and so the quality of its services, by:
- Mortality rates remain as expected and other benchmarking, including HSMR remains one of the Trust quality priorities for 2015/16 and the Mortality Board maintains ongoing oversight of any indicators that flag as an outlier.

Indicator: Readmission rates

The percentage of patients readmitted to a hospital which forms part of the Trust within 28 days of being discharged from a hospital which forms part of the Trust during the reporting period.

	Reporting period	L&D Score	National Average	Highest score (worst)	Lowest score (best)
Patients aged 0 – 15 years	2010/11	13.78	10.04	14.76	0.0%
	2011/12	13.17	9.87	13.58	0.0%
	2012/13	Not Avail*	Not Avail*	Not Avail*	Not Avail*
	2013/14	Not Avail*	Not Avail*	Not Avail*	Not Avail*
	2014/15	Not Avail*	Not Avail*	Not Avail*	Not Avail*
	2015/16	Not Avail*	Not Avail*	Not Avail*	Not Avail*
Patients aged 16 years and over	2010/11	10.16	11.17	13.00	0.0%
	2011/12	10.64	11.26	13.50	0.0%
	2012/13	Not Avail*	Not Avail*	Not Avail*	Not Avail*
	2013/14	Not Avail*	Not Avail*	Not Avail*	Not Avail*
	2014/15	Not Avail*	Not Avail*	Not Avail*	Not Avail*
	2015/16	Not Avail*	Not Avail*	Not Avail*	Not Avail*

The Luton and Dunstable University Hospital considers that this data is as described for the following reasons:
- This is based upon clinical coding and the Trust is audited annually.
- The Trust does not routinely gather data on 28 day readmission rates

The Luton and Dunstable University Hospital has taken the following actions to improve this percentage, and so the quality of its services, by:
- We will continue to work with our commissioners to prevent unnecessary readmissions to hospital through admission

avoidance services available for patients to access. These include Ambulatory care Unit, the Acute Rapid Access Service (ARAS) for respiratory patients, the Navigation Team, the Hospital at Home service, provider support in the Emergency Department and the integrated models of care

*The most recent available data on The Information Centre for Health and Social Care is 2011/12 uploaded in December 2013. The next information upload is in August 2016.

Indicator: Patient Reported Outcome Measures (PROMs) scores

PROMs measure a patient's health-related quality of life from the patient's perspective using a questionnaire completed by patients before and after four particular surgical procedures. These questionnaires are important as they capture the extent of the patient's improvement following surgery.

	Reporting period	L&D Score	National Average	Highest score (best)	Lowest score (worst)
Groin hernia surgery	2010/11	0.110	0.085	0.156	-0.020
	2011/12	0.12	0.087	0.143	-0.002
	2012/13	0.09	0.085	0.157	0.014
	2013/14*	0.079	0.085	0.139	0.008
	2014/15	0.088	0.081	0.125	0.009
	2015/16	**	0.088	0.13	0.08
Varicose vein surgery	2010/11	**	0.091	0.155	-0.007
	2011/12	**	0.095	0.167	0.049
	2012/13	**	0.093	0.175	0.023
	2013/14*	**	0.093	0.15	0.023
	2014/15	**	0.1	0.142	0.054
	2015/16	**	0.1	0.13	0.037
Hip replacement surgery	2010/11	0.405	0.405	0.503	0.264
	2011/12	0.38	0.416	0.499	0.306
	2012/13	0.373	0.438	0.543	0.319
	2013/14*	0.369	0.436	0.545	0.342
	2014/15	**	0.442	0.51	0.35
	2015/16	**	0.45	0.52	0.36
Knee replacement surgery	2010/11	0.325	0.299	0.407	0.176
	2011/12	0.313	0.302	0.385	0.181
	2012/13	0.321	0.319	0.409	0.194
	2013/14*	0.297	0.323	0.416	0.215
	2014/15	**	0.328	0.394	0.249
	2015/16	**	0.334	0.412	0.207

The Luton and Dunstable University Hospital considers that this data is as described for the following reasons
- Results are monitored by the Clinical Audit and Effectiveness Group
- Results are monitored and reviewed within the surgical division

The Luton and Dunstable University Hospital has taken the following actions to improve this score, and so the quality of its services, by:
- Reviewing these results in both high level committees and within the surgical division.
- Emphasising the importance of submission of good returns and the satisfactory outcome scores achieved in multidisciplinary staff meetings.
- Patient level data is scrutinised and surgical team performance reviewed. The Trust completed a review in April 2015 that identified no concerns at the patient level.

- This is reported to the Clinical Operational Board by the divisional director with areas of performance highlighted where required

* Relates to April to September 2015 (most recent data published in February 2016 by HSCIC)
** Score not available due to low returns

Indicator: Responsiveness to the personal needs of patients during the reporting period

This measure is taken from the National Inpatient Survey and is scored based on the response to five key questions:
- Were you involved as much as you wanted to be in decisions about your care and treatment?
- Did you find someone on the hospital staff to talk to about your worries and fears?
- Were you given enough privacy when discussing your condition or treatment?
- Did a member of staff tell you about medication side effects to watch for when you went home?
- Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?

	Reporting period	L&D Score	National Average	Highest score (best)	Lowest score (worst)
Responsiveness to the personal needs of patients.	2010/11	65.6	67.3	82.6	56.7
	2011/12	64	67.4	85	56.5
	2012/13	67.5	68.1	84.4	57.4
	2013/14	65.6	68.7	84.2	54.4
	2014/15	66	68.9	86.1	59.1
	2015/16	Not Avail*	Not Avail*	Not Avail*	Not Avail*

The Luton and Dunstable University Hospital considers that this data is as described for the following reasons
- The source of the data is the National In-Patient Survey.

The Luton and Dunstable University Hospital intends to take the following actions to improve this score, and so the quality of its services, by:
- Continued implementation of Electronic Prescribing system and that has improved timeliness of available medications for patients to take home
- On-going refurbishment programme to assess the high risk environmental areas that need attention particularly toilets and bathrooms
- On-going monitoring of patient feedback from the Patient Experience Call Centre and Friends and Family feedback

*The most recent available data on The Information Centre for Health and Social Care is 2013/14

Indicator: Staff recommendation

The percentage of staff employed by, or under contract to, the Trust during the reporting period who would recommend the Trust as a provider of care to their family or friends.

	Reporting period	L&D Score	National Average	Highest score (best)	Lowest score (worst)
Percentage of staff who would recommend the Trust as a provider of care to family and friends when compared to other acute providers.	2010/11	57%	66%	95%	38%
	2011/12	57%	65%	96%	33%
	2012/13	61.5%	63%	94%	35%
	2013/14	67%	67%	89%	38%
	2014/15	67%	65%	89%	38%
	2015/16	72%	70%	*	*

The Luton and Dunstable University Hospital considers that this data is as described for the following reasons
- The source of the data is the National Staff Survey.

The Luton and Dunstable University Hospital has taken the following actions to improve this score, and so the quality of its services, by:

- The hospital runs with a clinically led, operating structure.
- The Chairman and Non-Executive Directors have a programme of clinical visits and the experiences of each visit is reported to the Clinical Outcomes, Safety and Quality Committee.
- Transforming Quality Leadership Group in place and supports areas across the Trust through a 'buddy' process.

* Not available on the HSCIC website

Indicator: Risk assessment for venous thromboembolism (VTE)

The percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism (VTE) during the reporting period.

	Reporting period	L&D Score	National Average	Highest score (best)	Lowest score (worst)
Percentage of patients who were admitted to hospital and who were risk assessed for VTE.	2010/11 – Q4	90.3%	80.8%	100%	11.1%
	2011/12 - Q4	96.1%	92.5%	100%	69.8%
	2012/13 – Q4	95.3%	94.2%	100%	87.9%
	2013/14 – Q4	95.1%	96.1%	100%	74.6%
	2014/15 – Q4	95%	96%	100%	74%
	2015/16 – Q3	95.7%	95.5%	100%	94.1%

The Luton and Dunstable University Hospital considers that this data is as described for the following reasons

- There is a robust process for capturing the evidence of completion

The Luton and Dunstable University Hospital has taken the following actions to improve this score, and so the quality of its services, by:

- The hospital has and will continue to ensure that all clinical staff are aware of the importance of timely VTE risk assessment of patients. This is undertaken at induction and through clinical bedside teaching.
- There is daily clinical review and for any patient that have not been risk assessed, there is a follow up action to ensure that this is undertaken; this has resulted in achieving 95% and above throughout 2015/16.
- We are planning to implement an electronic solution to the risk assessment process.
- We undertake root cause analysis on all patients who develop a VTE.

Indicator: Clostridium difficile infection rate

The rate for 100,000 bed days of cases of Clostridium difficile infection reported within the Trust amongst patients aged 2 or over during the reporting period.

	Reporting period	L&D Score	National Average	Highest score (worst)	Lowest score (best)
Rate for 100,000 bed days of cases of C. difficile infection reported within the Trust amongst patients aged 2 or over.	2010/11	20.0	29.6	71.8	0
	2011/12	19.4	21.8	51.6	0
	2012/13	9.0	17.3	30.8	0
	2013/14	9.9	14.7	37.1	0
	2014/15	5.1	15.1	62.2	0
	2015/16	5.1	Not Avail*	Not Avail*	Not Avail*

The Luton and Dunstable University Hospital considers that this data is as described for the following reasons
The accuracy of the data is checked prior to submission. The data is also cross checked with laboratory data and verified before reporting to the Board.

The Luton and Dunstable University Hospital has taken the following actions to improve this score, and so the quality of its services, by:

- maintaining *C.difficile* high on the training agenda for all healthcare staff
- rigorously investigating all cases of *C.difficile* through the RCA mechanism and actioning all learning points identified
- assessing all patients suspected of *C.difficile* infection when alerted
- uncompromisingly isolating suspected cases of *C.difficile* when first identified
- attending the CCG Infection Control Network with its potential for shared learning
- monitoring high standards of environmental cleaning (including equipment) and exploring other mechanisms of reducing *C.difficile* contamination further

*Data not available on Health and Social Care Information Centre

+ Local Data

Indicator: Patient safety incident rate

The number and, where available, rate of patient safety incidents reported within the Trust during the reporting period, and the number and percentage of such patient safety incidents that results in severe harm or death.

	Reporting period	L&D Score	National Average	Lowest score (worst)	Highest score (best)
Total number and rate of patient safety incidents (per 1000 bed days) when benchmarked against medium acute trusts	2010/11	**	**	**	**
	2011/12	**	**	**	**
	2012/13	**	**	**	**
	2013/14	**	**	**	**
	2014/15	37.52	35.1	17	72
	2015/16	34.9	38.2	18	74
Total number and rate of patient safety incidents resulting in severe harm or death when benchmarked against medium acute trusts	2010/11	0.03	0.04	0.17	0
	2011/12	0.03	0.05	0.31	0
	2012/13	0.03	0.05	0.26	0
	2013/14	0.03	0.05	0.38	0
	2014/15	0.25	0.19	1.53	0.02
	2015/16	Not Avail*	Not Avail*	Not Avail*	Not Avail*

The Luton and Dunstable University Hospital considers that this data is as described for the following reasons

- The hospital reports incident data and level of harm monthly to the National Reporting and Learning System
- 32 Serious Incidents were reported in 2015/16 compared to 46 in 2014/15 and 36 in 2013/14 (excluding pressure ulcers).
- The Trust reported 3 Never Events in 2015/16 under the following Department of Health criteria - a wrong route injectable medicine, a wrong patient procedure and a retained foreign object post-procedure. The Trust was also made aware by HM Coroner of a retained foreign object following a surgical procedure carried out in 2001. The inquest concluded that the patient's disease processes and the presence of swab contributed to his death and for which the Trust has apologised. The systems and processes that were in place in 2001 have since been revised and following the introduction of the World Health Organisation Safer Surgical Checklist (2009), the introduction of the Never Event list by the Department of Health (2009) and changes in clinical practice to the procedure that was performed, the Trust is confident that this type of event cannot recur.
- The Trust is contractually required to notify its Commissioners of a Serious Incident within 2 working days of identification – in 2015/16 this target was met in 21 out of 32 cases (66%).
- The Trust is also contractually required to submit an investigation report for all Serious Incidents within 60 working days of the notification. During 2015/16 this target was met in 20 out of 26 cases (77%). Six incidents were still under investigation at the time of data collection but it is anticipated that these would all meet their deadlines for submission.
- The Trust continues to review its systems and processes to ensure it can meet the contractual requirements going forward.
- The Trust was 100% compliant with the Duty of Candour contracted requirements for serious incidents as documented.

The Luton and Dunstable University Hospital has taken the following actions to improve this score, and so the quality of its services, by:

- The hospital has a low level of serious harm or death, however strives to continue to improve this through improved falls prevention, pressure ulcer avoidance mechanisms and improved learning from serious incidents.
- The hospital is a high reporting organisation and this demonstrates a culture of patient safety and openness. The hospital continues to ensure that patient safety is a quality priority and will continue to drive improvements through
- Learning from incidents is shared through Divisional Governance, Grand Rounds and Safety Briefings plus two special 'Patient Safety News' newletters were issued too staff through a Trust engagement event during the year particularly focusing on learning from Serious Incidents. Examples of learning include:
  - Any changes to the patient's nutritional status is communicated on the Patient Information board as soon as reasonably practicable.
  - The NIV assessment tool now includes SBAR principles to facilitate more effective handover.
  - The SAD mental health assessment tool was implemented in the Emergency Department (ED) to provide greater clarity on the management of the patients who are at risk of self harm.
  - Implemented CTG mandatory training for all obstetric staff and midwives.
  - Reviewed induction checklists.
  - Put in place formal structure ward rounds on the labour ward.
  - Enhanced the communication processes with GP surgeries from ED.

*Data not available on Health and Social Care Information Centre

** NRLS amended their calculation from per 100 bed days to per 1000 bed days in 2013 so no comparable historical data available

5.9 Embedding Quality – Workforce factors

Our success is delivered through our people and as such our staff continue to be our most valuable asset when it comes to delivering clinical excellence, quality and safety to our patients. We strive to achieve this through many different routes, including delivery of learning and development; good leadership and good communication. This journey starts from the point that an individual applies for a post with us and continues through their employment with the Trust.

Recruitment

In recent years we have been particularly busy in terms of the recruitment of staff both clinical and non-clinical. This has continued throughout 2015/16 where we advertised 1018 posts advertised that resulted in 946 new starters (excluding bank starters, staff transferring from bank to permanent posts and existing staff being promoted).

The Trust put a particular emphasis on the recruitment of Registered Nurses and Health Care Assistants and below we set out some of the work that we have been doing.

Registered Nurse Recruitment

In addition to recruiting locally through newly qualified student nurses and holding bi-monthly recruitment open days. We have also looked nationally and have been proactive in participating in Recruitment Fairs in Scotland, Belfast and Dublin.

The Trust has also looked further afield in Europe (Portugal, Italy and Spain) as well as campaigns in India and the Philippines.

Health Care Assistants (HCAs)

Throughout the year bi-monthly HCA recruitment campaigns have been held and these have resulted in 115 HCAs commencing in post. We have also held additional open days for some speciality campaigns, for instance Theatres HCAs.

The development and progress of HCAs is monitored through completion of the induction Care Certificate competencies within 12 weeks of commencing at the Trust. This baseline competency programme is a national requirement for all care workers. For care assistants without a level two qualification as part of their employment, 54 HCAs have commenced a Clinical Apprenticeship in General Healthcare following on from their induction. This contributes greatly to the employer's apprenticeship targets set by Health Education East of England HEEoE).

The Foundation Degree, (FD) is the qualification required of our Assistant Practitioners (AP) currently being employed in specialist areas of the trust and more recently on general elderly care wards. From the September 2015 intake, we have three completing the foundation degree. APs are skilled up to the first year of a Student nurse academically with four or more years of practical

experience having completed level two and three general healthcare qualifications. The medical division have now employed eight new APs across the wards.

The FD, plus Maths and English at level two is also the entry requirements for those who wish to undertake the new Flexible Nursing Pathway being developed in partnership with the University of Bedfordshire, HEEoE and local service providers including the L&D. For the flexible nursing pathway students can work towards a nursing degree and study alongside the traditional three year students. Students are required to work for three days per week in their normal role and undertake the requirements of the nursing programme on the other two days per week. The students are jointly funded by the employer and the HEEoE. In March 2016, five of our staff have commenced this exciting new programme.

Sickness Absence Project

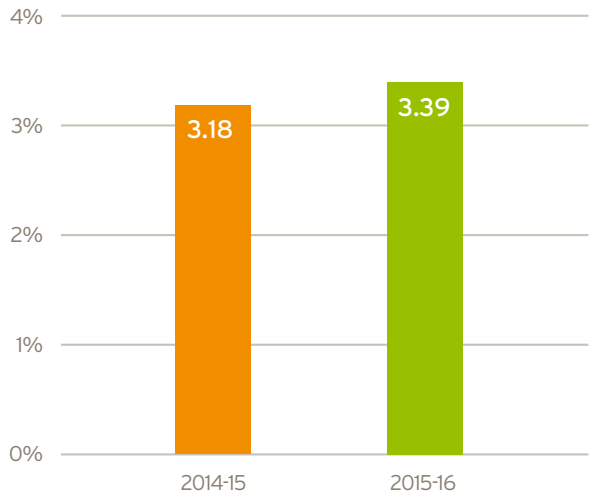
The sickness absence project has been running for just over two years during which time we have seen a significant reduction in sickness absence levels across the Trust.

The project has delivered a cultural shift towards managing sickness absence with a more proactive action orientated approach being adopted by line managers to address sickness absence caseloads. This has included coaching and training of line managers and also delivering the message that sickness absence management is for all employees. In addition, it has reached across other areas to change the culture within the Trust realigning mindsets and behaviours, including Recruitment & Resourcing, ensuring that the right people are recruited with the right skill set for the right positions with the appropriate controls and processes.

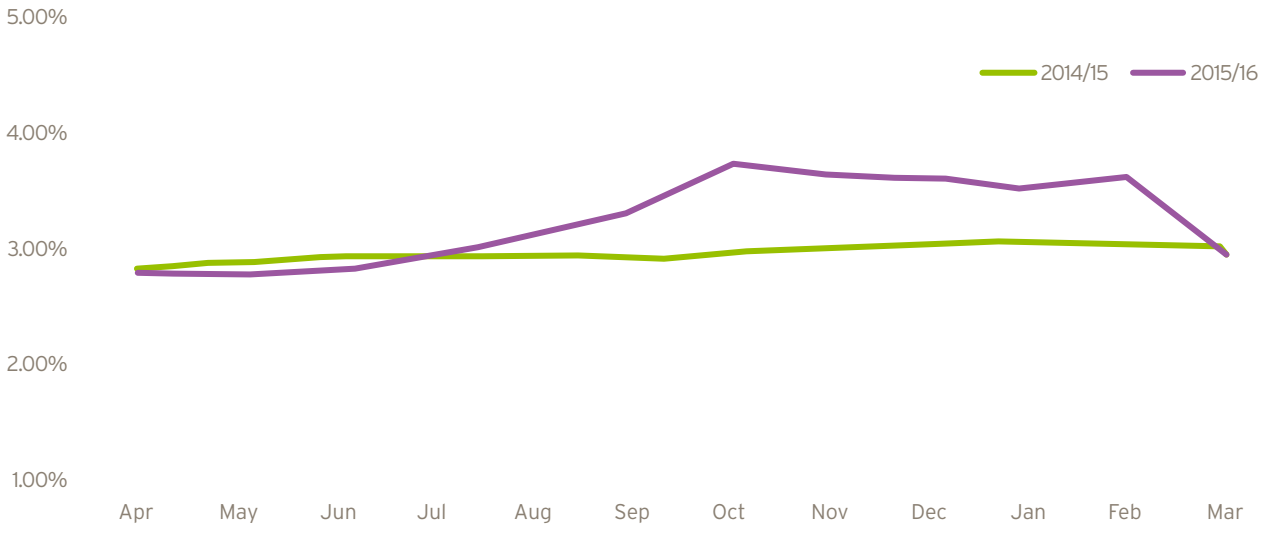
As a result of this focus, the Trust has one of the lowest sickness absence rates of any acute Trust in the East of England and one of the leading Acute Trusts across NHS England when it comes to sickness absence rates.

We are now moving into a phase of sustainability and continuing to embed the principles of absence management whilst ensuring that absence is continually managed through meaningful dialogue and in line with the Trust policy.

Full Year Sickness Absence Rates 14/15 and 15/16



% Sickness absence rates



Staff Engagement and Consultation
The L&D takes pride in having a healthy and productive relationship with staff and this is reflected in the staff engagement scores in the Staff Opinion Survey, where this year was again higher than the national average. In addition, the Trust scored in the top 20% of Trusts across the country with 73% of staff reporting that they were able to contribute towards improvements at work, good, communication between senior management and staff was also found to be above (better than) average.

Staff Recognition
There have been a number of opportunities over the year to thank staff and volunteers for their contributions. In particular:

- In recognition of their long service, staff were invited to an awards event at Luton Hoo Hotel in February 2016. This was the Trust Board's way of thanking staff who made a significant contribution to the Trust over the last 25 years. The event was enjoyed by all who attended and many happy memories were shared in respect of service over the years.

  During National Volunteers week held in June 2015, we arranged a day trip to the seaside for our volunteers, which was a very enjoyable day. A further event was held in in January 2016 where 80 volunteers enjoyed an afternoon at the Pantomime at a local theatre.

Communicating and engaging with our staff
The Trust recognises that communicating and engaging with our staff is a key part of our success. Feedback from the 2015 Staff Survey showed that the Trust scored above average for its overall staff engagement score. Similarly, we scored above average for the percentage of staff reporting good communication between senior management and staff.

Having a committed and engaged workforce contributes directly to the quality of the care we provide to our patients. Messages are delivered in a variety of ways both within individual teams and department and across the Trust as a whole.

Examples of staff communications and engagement include:

- Weekly face-to-face staff briefings are led by our Executive Team, where we share information on key operational issues
- Established local newsletters are in place across divisions, departments and wards to share good practice and learning within teams
- A fortnightly newsletter is sent to all nursing staff, which includes information on patient safety issues. During the coming year, we are working to broaden the scope of this newsletter to include other groups of clinical staff
- A bi-monthly newsletter is sent to all Trust staff, developed by the Staff Involvement Group, which includes stories from staff about health and wellbeing and the contributions they make to the Trust and our local community
- Key time-sensitive messages are cascaded to all staff via our intranet and email systems
- Regular meetings are held with senior leaders in our clinical divisions to share information with and receive feedback from frontline colleagues
- Our Trust Board meets monthly with our Council of Governors, which includes eight elected staff governors

Staff governors actively speak directly to colleagues to gather their thoughts and ideas about how to improve working lives at the Trust
- The Joint Staff and Management Council (JSMC). This is a meeting of staff side representatives and senior managers of the Trust. The meeting is used to develop and consult on policies and any other matters that affect staff. The staff side JSMC representatives have been particularly supportive in the implementation of many initiatives where there has been a workforce implication, including providing support on change management consultations with staff. Regular meetings are held with senior managers and the Human Resources team to engage in discussion over formal consultations.
- Staff Involvement Group

The focus of this group is on developing a culture of staff involvement, open communication and partnership working with factors that have a real impact on staff such as reward and recognition, security, health and wellbeing. The membership of the group is diverse and members are active in taking forward themes from the staff opinion survey and 'testing the ground' with staff initiatives to improve the patient experience.

Engagement events 2015
During the summer of 2015, over 68% of all Trust staff attended a series of engagement events hosted by the Chief Executive, during which staff from all departments identified the aspects of their working lives that they are most proud of, along with the key issues they wanted the Trust to take action on in their areas. These events were a direct response to feedback from staff in 2014, when our Chief Executive asked all staff via a survey and face to face meetings for feedback on improving communication.

As a result of the positive feedback received from staff a further engagement event was repeated during a week in December 2015, where a similar number of staff attended. The December events included detailed feedback from the summer events, with a comprehensive booklet given out to every attendee, as well as information to support staff in the lead up to our Care Quality Commission inspection in January 2016.

During the December events, we asked staff to list the top two strengths of their team and the Trust, as well as two areas where we needed to make improvements and how we were doing this. This information was shared with all teams for their individual areas in advance of the CQC inspection. Overall feedback was positive and constructive, as shown in the following summary.

Things our staff are proud of:

- The patient is at the heart and centre of all we do every day
- Patient feedback is excellent and most patients have a good experience
- Staff work well together in teams and across teams to support each other and to ensure the patient always has a good experience
- The Trust is collaborative and innovative
- Teams are good at communicating with one another
- Managers and senior leaders are visible and available
- The Trust is a good place to work and our culture and clinical reputation help attract new staff

Things our staff feel we need to improve on:

- Availability of specific equipment
- Availability of space to provide services
- Having sufficient time to complete training and on-going development
- Having the right staffing in all services

Staff Involvement Group Newsletter

The newsletter is produced every two months and is full of articles and stories for staff, by staff and about staff. The aim is for staff to be involved in something that is purely for them, and is a method for individuals to share their stories such as personal achievements, smoking cessation, weight loss, hobbies/interests or a new fitness regime that could inspire others to take action to live healthier lifestyles.

2015 National Staff Survey Results

The 12th National Staff Survey was undertaken between September and December 2015. All Trusts are required to participate in the survey using a random sample of staff and the data from which is used by the CQC for the Benchmark Reports across all NHS Acute Trusts.

Staff Engagement

The survey measures overall Staff Engagement and the Trust scores are detailed as follows:

Key Finding	Score	Ranking
Overall Staff Engagement	3.74	Above (better than) average
Staff recommendation of the Trust as a place to work or receive treatment	3.67	Above (better than) average
Staff motivation at work	3.86	Average
Staff ability to contribute towards improvements at work	68%	Highest (best) 20%

Key Findings

A summary of the key findings from the 2015 National NHS Staff Survey are outlined in the following sections:

Top Ranking Scores

Key Finding	Score	Ranking
% of staff reporting good communication between senior management and staff	35%	Above (better than) average
% of staff able to contribute towards improvements at work	73%	Highest (best) 20%
Quality of appraisals	3.31	Highest (best) 20%
Quality of non-mandatory learning or development	4.08	Highest(best) 20%
Fairness and effectiveness of procedures for reporting errors, near misses and incidents	3.76	Above (better than) average

Other Key Findings that scored above or below (better than) average

- Effective team working
- Staff satisfaction with resourcing and support
- % of staff suffering work related stress in last 12 months
- % of staff experiencing physical violence from staff in last 12 months
- % of staff witnessing potentially harmful errors, near misses or incidents in last month
- % of staff reporting errors, near misses or incidents witnessed in the last month
- Fairness and effectiveness of procedures for reporting errors, near misses and incidents

Bottom Ranking Scores

Key Finding	Score	Ranking
Support from immediate managers	3.64	Below (worse than) average
% of staff appraised in the last 12 months	81%	Below (worse than) average
% of staff satisfied with the opportunities for flexible working patterns	46%	Below (worse than) average
% of staff working extra hours***	75%	Highest (worst) 20%
% of staff/colleagues reporting most recent experience of harassment, bullying or abuse	31%	Below (worse than) average

*** Whilst KF 16 is an amalgamation of both paid and unpaid hrs, a further breakdown indicates the following:-

Response –unpaid extra hours	National	L&D	Response –paid extra hours	National	L&D
0 hours per week	42%	37%	0 hours per week	66 %	57 %
Up to 5 hours per week	45%	50%	Up to 5 hours per week	18 %	21 %
6 – 10 hours per week	9%	8%	6 – 10 hours per week	9 %	13 %
11 or more hours	4%	4%	11 or more hours	7 %	9 %

Other Key Findings that scored above or below (worse than) average

- KF 18 - % of staff feeling pressure in the last 3 months to attend work when feeling unwell
- KF20 - % of staff experiencing discrimination at work in the last 12 months
- KF24 - % of staff/colleagues reporting most recent experience of violence
- KF25 - % of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months
- KF26 - % of staff experiencing harassment, bullying or abuse from staff in last 12 months
- KF32 – Effective use of patient/service user feedback

The Staff survey results for 2015 are positive. We maintained an above average staff engagement score and also demonstrated an improvement in Staff recommendation of the organisation as a place to work or receive treatment.

We are extremely proud that the quality of non-mandatory learning and development and quality of appraisals are within the highest (best) 20% of Trusts, and despite the survey findings indicating that the percentage of staff being appraised in the last 12 months appears to be below average we know that our most recent actual statistics demonstrate that we have achieved the highest rate that the Trust has ever seen.

On the whole we are very pleased with the outcomes within the Staff survey, but acknowledge that there are areas where further action is required. Feedback is provided to all of the Divisions and as a result action plans are developed to support improvements in the areas required.

5.10 Improving the quality of our environment

Whilst the Trust continues to develop and consolidate ideas for the redevelopment of the hospital site, parts of the existing hospital estate will be retained over the longer term. During 2015/16, we have therefore carried out an extensive programme of works to refurbish corridors, lift lobbies, outpatient areas and wards. The works have been designed to improve the general environment of these areas, and include:-

- New flooring
- New suspended ceilings (in corridors)
- Upgraded lighting with energy efficient LED based systems

- New wall protection fittings to prevent damage to walls from equipment such as patient beds
- General redecoration

In addition to redecoration, improvement works were completed on inpatient wards 10, 11 and 12 to improve privacy and dignity for patients.

We introduced a commercial partner – Engie - during 2015/16 to run our cleaning and catering services. Engie have now completed the refurbishment of the Chiltern Restaurant with new food counters and a new range of meal options.

In addition to the planned refurbishment works the 'Urology One Stop Centre' development was completed and opened to patients in September 2015. This new facility provides a suite of new consulting and treatment rooms enabling patients to be treated in an outpatient setting. In November 2015, our new orthopaedic centre opened in a vacant part of the Travelodge on Dunstable Road, approximately half a mile from the main hospital site with dedicated parking. The new centre provides care in a modern environment, whilst also freeing up space within the Emergency Department in the main hospital.

We have continued to actively engage with patients via PLACE (Patient Led Assessment of the Care Environment) Committee. The Committee is formed of a mix of staff and patients who undertake to carry out monthly inspections of the care environment providing valuable feedback on where improvements can be made for the benefit of patients. This work feeds into an annual inspection which is reported into the Department of Health.

5.11 Quality and Business Strategy

One of our key approaches to delivering high quality sustainable care is our Reengineering programme focused on delivering care more efficiently and effectively. This is a formal programme to resolve the fact that overall systems and processes are not functioning to a maximum level of efficiency and that potential improvements represent a key opportunity to improve both quality and efficiency.

The overarching governance is through monthly dedicated Executive Board, and at Board Committee level through the Finance, Investment and Performance Committee. The Trust has a dedicated Executive Director to ensure delivery. Each scheme is described below and has its own project structure and quality impact assessment.

Outpatient Re-engineering was the Re-Engineering focus for the year 15/16 aiming to substantially improve staff and patient experience in our busiest area of clinical activity.

This year has been focused on what we have described as a "Partial Booking" implementation. This means that for patients requiring an appointment more than 6 weeks in advance a waiting list is maintained. Partial Booking is now live for over half of our bookings. This has required considerable design of optimised central support processes for specialities. There has been a very positive impact on reducing appointment rescheduling in areas that are live and established with a decrease from 13.5% to 1.6% of patients having multiple moves of their follow-up appointments. This has also seen did not attend (DNA) rates decrease by 1.6% to almost 8%. Given this impact there is an urgent focus to get this service improvement across all follow-up appointments by the summer of 2016.

Also within Outpatients we have completed detailed work to examine the flow of activity within clinics using improvement science techniques to refine our approach speciality by speciality. This has focused on 3 representative specialities: Orthopaedics, Respiratory, ENT and Neurology. Using external expertise we combined an understanding of the pathway, the balance of capacity and demand for a pathway, and also optimised support and flow.

Last year we completed the tender for a Patient Self-Check-In and Flow solution for Outpatients to transform our patients' journey from arrival at the site, to arrival in the clinical room for the appointment. This included screens to guide the patient, and manage expectations around timing in a similar manner to the flow through an airport. However, the implementation of the solution was put on hold due to the potential impact of changing the Trust's patient administration system (PAS).

eRostering: The roll-out of eRostering to nursing and other non-medical staff completed this year, including the most complex area such as Theatres and Delivery Suite. The effectiveness of established staff utilisation has seen consistent improvement across the year. The Trust has also scoped and designed an extension of this system to cover the entire workforce, including trainee medical staff. The push for Carter efficiencies; the drive to control agency rates and usage, and the need to ensure we are using our established contracted hours to deliver maximum safety for the funds spent, have all shown the critical who are actively looking to extend this functionality to trainee doctors. There is, however, much more work to be completed using the system to deliver the best use of staff resources.

A Unified PAS/ePR for the Trust: Considerable work was completed preparing an investment case for the Lorenzo Regional Care system. The Trust successfully passed through two of the three gateways to access central funding, but the launch of the Sustainability and Transformation Plan (STP) process, where the Trust is working across a wider footprint has led to a hiatus while all options are considered.

Business Development: The Trust has continued to market its services to GPs and held a range of events to promote our services, where expert speakers have drawn consistently good attendances. These will continue, but will take place on the margin of our traditional catchment areas. We have worked hard to ensure we are the easiest place to refer to clinically, the quickest place to see patients, and can clearly evidence and promote the quality of our services. This will involve enhanced investment in marketing materials, but will require careful alignment with capacity released by re-engineering our processes. We have launched a strategically important maternity hub in Leighton Buzzard including the delivery of antenatal imaging conveniently located for local appointments. We have also been successful in securing a contract to deliver an innovative modern Sexual Health service for the area of Luton.

5.12 Review of Quality Performance - how the Trust identifies local improvement priorities

The hospital agreed the Corporate Objectives for 2014 – 2016, and these include the quality objectives. The Trust Governors were engaged with the development of these objectives.

The list of clinical indicators which were developed and added to in previous years remain included. People identified those indicators most important to them and also stated the elements of care that they would want the Trust to concentrate on improving.
Amendments to the quality priorities have been considered by staff in management executive based on performance and improvement needs.
Quality is discussed and monitored at quarterly monitoring meetings with our local Clinical Commissioning Groups. There remains a high level of agreement among the various groups of people that have contributed to determining priorities.

6. Statement of Directors' responsibilities in respect of the Quality Report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

Monitor has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support the data quality for the preparation of the quality report.

In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

- the content of the Quality Report is not inconsistent with internal and external sources of information including:
  - board minutes and papers for the period April 2015 to March 2016
  - papers relating to Quality reported to the board over the period April 2015 to May 2016
  - feedback from commissioners dated 17/05/16 and 24/05/16
  - feedback from governors dated 10/02/2016
  - feedback from local Healthwatch organisations received [not received at time of signing]
  - feedback from Overview and Scrutiny Committee (Luton OSC are not providing feedback and Bedfordshire OSC are reviewing the account on the 31/05/16)
  - the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 28/08/15, 23/10/15, 25/01/16 and 25/04/16
  - the 2015 national patient survey 25/05/2016
  - the 2015 national staff survey 24/02/2016
  - the Head of Internal Audit's annual opinion over the trust's control environment dated 18/5/16
  - CQC Intelligent Monitoring Report dated May 2015

- the Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered;

- the performance information reported in the Quality Report is reliable and accurate; We have robust processes in place to capture incidents. However there are risks at every Trust relating to the completeness of data collected for all incidents (regardless of their severity) as it relies on every incident being reported. Whilst we have provided training to staff and there are various policies in place relating to incident reporting, this does not provide full assurance that all incidents are reported. We believe this is in line with all other Trusts.

- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice;

- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and

- the Quality Report has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the Quality Accounts regulations) (published at www.monitor.gov.uk/annualreportingmanual) as well as the standards to support data quality for the preparation of the Quality Report (available at www.monitor.gov.uk/annualreportingmanual).

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report.

By order of the board

25th May 2016
Chairman

25th May 2016
Chief Executive

Note: An Equality Analysis has been undertaken in relation to this Quality Account.

7. Comments from stakeholders

Statement from Luton Clinical Commissioning Group to Luton and Dunstable University Hospital NHS Foundation Trust Quality Account 2015/16

Luton Clinical Commissioning Group (CCG) welcomes the opportunity to comment on the 2015/16 Quality Account* for Luton and Dunstable University Hospital NHS Foundation Trust (LDH).

We have been working closely with the Trust during the year, gaining assurance on the delivery of safe and effective services. In line with the NHS (Quality Accounts) Regulations 2011, Luton CCG have reviewed the information contained within the LDH annual account and checked this against data sources, where this is available to us as part of our existing monitoring discussions, and confirm this to be accurate.
We acknowledge the work undertaken by LDH in 2015/16 in response to national quality initiatives regarding the improvement of managing patients with acute kidney injury. The increased compliance with completing discharge summaries (90%) has contributed positively to patient experience and safety and improved care pathway continuity. We look forward to working with the Trust as they continue with this quality priority in 2016/17

We recognise the commitment of the Trust in implementing recommendations from national enquiries and guidance including the work on safe staffing levels within in-patient wards. We particularly acknowledge the commitment by the Trust to increase staffing through active recruitment campaigns both here and abroad.

Luton CCG had been concerned about the poor quality and timeliness of Serious Incident investigations and reports which was compounded by the slow progress of the Trust in making improvements. Luton CCG would, however, like to take this opportunity to commend LDH for their continued improvement and recognise the efforts that the Trust has made to ensure that serious incident reports are completed within Nationally set time frames and that the quality of the reports have improved to a high standard.

Current NHS reforms emphasise the need to integrate care more effectively between acute hospitals and the community. LDH have been involved in the Integrated Care Strategy and, whilst progress has been made in taking forward the integration and coordination of care, success will be demonstrated by fewer admissions, shorter stays in hospital and improved patient experience. This initiative has continued throughout 2015/16 with the introduction of a needs based care approach for immobile patients and patients in care homes and has given GPs easier access to specialist opinions.

Over the last year LDH has steadily improved it's level of compliance required for the stroke programme. We look forward to seeing the Trust reach its targets in patient related outcomes in 2016/17 and will be successful in their plan to develop a Hyper Acute Stroke Unit.

We welcome the Trust's commitment to participation in national and local audits and we will continue to support the Trust to ensure that their services use the outcomes of these audits to drive further quality improvements.

Luton CCG fully supports the Trust's quality priorities and indicators for 2016/17 as set out in this annual account. The continued focus on improving the experience for patients, approaching end of life and for those with dementia and delirium is evident in the initiatives outlined. The Trusts focus on reducing mortality rates by focusing on the recognition and treatment of the deteriorating patient. Luton CCG will monitor the progress of the Trust in driving forward these initiatives and improvements to ensure high quality healthcare and outcomes for the people of Luton.

At the time of writing this commentary we are unable to validate the final figure for the Commissioning for Quality and Innovation (CQUIN) scheme as we are awaiting further information but it is anticipated that the Trust have achieved approximately 80% of their 2015/16 CQUIN.

Carol Hill
Chief Officer
Luton Clinical Commissioning Group

*It should be noted that these comments were made on an early draft of the LDH Quality Account received 28th April 2016.

Comments requested – 28th April 2016
Comments received – 24th May 2016

Central Bedfordshire Council's Social Care, Health and Housing Overview and Scrutiny Committee

As at the 24th May 2016, Central Bedfordshire Council are reviewing the Quality Account at their meeting on the 31st May 2016. These will be inserted for the final copy but do not form part of the External Audit Opinion.

Comments requested – 28th April 2016
Comments to be received – 31st May 2016

Comments from Luton Borough Council Health and Social Care Review Group

L&D Hospital NHS Foundation Trust Quality Accounts 2015-16

The Luton Health Scrutiny Committee will not comment specifically on any Quality Accounts for 2015/16

Comments requested – 28th April 2016
Confirmed no comments – 24th May 2016

Comments were requested from Healthwatch Luton and Healthwatch Bedfordshire.

Comments requested – 28th April 2016
Comments chased – 24th May 2016 – no comments received as at 25th May 2016

Comments from Luton Borough Council Health and Social Care Review Group

L&D Hospital NHS Foundation Trust Quality Accounts 2015-16

The Luton Health Scrutiny Committee will not comment specifically on any Quality Accounts for 2015/16

Comments requested – 28th April 2016
Confirmed no comments – 24th May 2016

Comments were requested from Healthwatch Luton and Healthwatch Bedfordshire.

Comments requested – 28th April 2016
Comments chased – 24th May 2016 – no comments received as at 25th May 2016

Comments received from the Trust Stakeholders

Comment	Response
Luton CCG requested further clarity on achievements against: - Integrated Care - 7 Day Services - Self-Check in and Partial Booking - End of Life Care	Included
Luton CCG requested Patient Stories and Improvements and more detail on learning from complaints	Included
Some acronyms are not included in the glossary	Included
Clarity on the Trusts' involvement in national clinical audit	Clarity Included

8. Independent Auditor's Assurance Report

Independent auditor's report to the council of governors of Luton and Dunstable University Hospital NHS Foundation Trust on the quality report

We have been engaged by the Council of Governors of Luton and Dunstable University Hospital NHS Foundation Trust to perform an independent assurance engagement in respect of Luton and Dunstable University Hospital NHS Foundation Trust's Quality Report for the year ended 31 March 2016 (the 'Quality Report') and certain performance indicators contained therein.

Scope and subject matter
The indicators for the year ended 31 March 2016 subject to limited assurance consist of the following two national priority indicators (the indicators):

- percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period; and
- A&E: maximum waiting time of four hours from arrival to admission/transfer/discharge.

Respective responsibilities of the directors and auditors
The directors are responsible for the content and the preparation of the Quality Report in accordance with the criteria set out in the NHS Foundation Trust Annual Reporting Manual issued by Monitor.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual;
- the Quality Report is not consistent in all material respects with the sources specified in the Detailed Guidance for External Assurance on Quality Reports 2015/16 ('the Guidance'); and
- the indicator in the Quality Report identified as having been the subject of limited assurance in the Quality Report are not reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and the six dimensions of data quality set out in the Guidance.

We read the Quality Report and consider whether it addresses the content requirements of the NHS Foundation Trust Annual Reporting Manual and consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the Quality Report and consider whether it is materially inconsistent with:

- board minutes and papers for the period April 2015 to May 2016;
- papers relating to quality reported to the board over the period April 2015 to May 2016;
- feedback from commissioners;
- feedback from governors;
- feedback from local Healthwatch organisations was requested on 28 April 2016 and has been followed up, however a response is yet to be received;
- feedback from Overview and Scrutiny Committee was requested on 28 April 2016 and has been followed up, however a response is yet to be received;
- the Trust's complaints reports published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009 dated 28 August 2015, 23 October 2015, 25 January 2016 and 25 April 2016;
- the national patient survey 25 May 2016;
- the national staff survey 24 February 2016;
- the 2015/16 Head of Internal Audit's annual opinion over the Trust's control environment; and
- the CQC Intelligent Monitoring Report of May 2015.

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with those documents (collectively, the 'documents'). Our responsibilities do not extend to any other information.

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.

This report, including the conclusion, has been prepared solely for the Council of Governors of Luton and Dunstable University Hospital NHS Foundation Trust as a body, to assist the Council of Governors in reporting the NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2016, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicator. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and Luton and Dunstable

University Hospital NHS Foundation Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

Assurance work performed
We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) – 'Assurance Engagements other than Audits or Reviews of Historical Financial Information', issued by the International Auditing and Assurance Standards Board ('ISAE 3000'). Our limited assurance procedures included:

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicator;
- making enquiries of management;
- testing key management controls;
- limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;
- comparing the content requirements of the NHS Foundation Trust Annual Reporting Manual to the categories reported in the Quality Report; and
- reading the documents.

A limited assurance engagement is smaller in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different, but acceptable measurement techniques which can result in materially different measurements and can affect comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision of these criteria, may change over time. It is important to read the quality report in the context of the criteria set out in the NHS Foundation Trust Annual Reporting Manual.

The scope of our assurance work has not included governance over quality or the non-mandated indicator, which was determined locally by Luton and Dunstable University Hospital NHS Foundation Trust.

Conclusion
Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2016:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual;
- the Quality Report is not consistent in all material respects with the sources specified in the Guidance; and
- the indicator in the Quality Report subject to limited assurance has not been reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and the six dimensions of data quality set out in the Guidance.

KPMG LLP

KPMG LLP
Chartered Accountants
London

26 May 2016

9. Glossary of Terms

Term	Description
Anticoagulation	A substance that prevents/stops blood from clotting
Arrhythmia	Irregular Heartbeat
Aseptic Technique	Procedure performed under sterile conditions
Cardiac Arrest	Where normal circulation of the blood stops due to the heart not pumping effectively.
CCG	Clinical Commissioning Group.
Chronic Obstructive Pulmonary Disease (COPD)	A disease of the lungs where the airways become narrowed
Clinical Audit	A quality improvement process that aims to improve patient care and outcomes by reviewing care against defined standards to support the implementation of change
Continence	Ability to control the bladder and/or bowels
Critical Care	The provision of intensive (sometimes as an emergency) treatment and management
CT	Computerised Tomography - Low Radiation Dose Computed Tomography (CT) uses low levels of radiation to help diagnose and monitor a wide array of conditions. A CT scanner has detectors which move around the body in a circular motion.
CT Coronary Angiography (CTCA)	CTCA uses new state of the art CT technology that is able to image a beating heart. This non-invasive examination makes visualisation of the coronary vessels possible and provides very useful diagnostic information for patients who are considered at high risk for coronary artery disease.
DME	Division of Medicine for the Elderly
Elective	Scheduled in advance (Planned)
EOL	End of Life
Epilepsy	Recurrent disorder characterised by seizures.
EPMA	Electronic Prescribing and Monitoring Administration system in place.
Grand Round	A lunch time weekly meeting with consultants and junior medical staff to communication key issues and learning.
HAI	Hospital Acquired Infection
Heart Failure	The inability of the heart to provide sufficient blood flow.
Hypercalcaemia	The elevated presence of calcium in the blood, often indicative of the presence of other diseases
HSMR	Hospital Standardised Mortality Rate. The HSMR is an overall quality indicator and measurement tool that compares a hospital's mortality rate with the overall average rate.
Laparoscopic	Key hole surgery
Learning Disability	A term that includes a range of disorders in which the person has difficulty in learning in a typical manner
LIG	Local Implementation Group
Meningococcal	Infection caused by the meningococcus bacterium
Magnetic Resonance Imaging (MRI)	A medical imaging technique that uses a powerful magnetic field and radiofrequency to visualise internal body structures
MUST	Malnutrition Universal Screening Tool is a nutritional assessment that is carried out on inpatients to ensure that they are maintaining their body weight
Myocardial Infarction	Heart attack when the blood vessels supplying the heart become blocked and heart muscle is damaged

Myringotomy	A surgical procedure of the eardrum which alleviates pressure caused by the build up of fluid
Neonatal	Newborn – includes the first six weeks after birth
Non Invasive Ventilation (NIV)	The administration of ventilatory support for patients having difficulty in breathing
Orthognathic	Treatment/surgery to correct conditions of the jaw and face
Parkinson's Disease	Degenerative disorder of the central nervous system
Partial Booking	A system where patients are not booked for their follow up until 6 weeks before their appointment reducing the chance of rescheduling
Perinatal	Period immediately before and after birth
Pleural	Relating to the membrane that enfolds the lungs
Safety Thermometer/Harm Free Care	Safety Thermometer/Harm Free Care is a 'call to action' for NHS staff who want to see a safer, more reliable NHS with improved outcomes at significantly lower cost. The care focus is on pressure ulcers, falls, Catheter acquired urinary tract infections, and Venous thromboembolism
Seizure	Fit, convulsion
Sepsis	The presence of micro-organisms or their poisons in the blood stream.
SEPT	South Essex Partnership University NHS Foundation Trust
SHMI	Summary Hospital-level Mortality Indicator (SHMI) is an indicator which reports on mortality at trust level across the NHS in England using a standard
Stroke	Rapid loss of brain function due to disturbance within the brain's blood supply
Syncope	Medical term for fainting and transient loss of consciousness
Two week wait	Target set nationally for the length of time patients have to wait for urgent tests for cancer diagnosis
Transfusion	Describes the process of receiving blood intravenously
Trauma	Physical injury to the body/body part
UTI	Urinary Tract Infection
Venous Thromboembolism (VTE)	A blood clot that forms in the veins

Research – Glossary of terms

Portfolio - studies which are eligible and have been accepted onto the National Institute for Health Research Clinical Research Network (NIHR CRN) Portfolio Database.

Non-Portfolio - studies which do not meet the eligibility criteria to be accepted onto the NIHR CRN Portfolio Database. (note: these are very worthwhile studies but are usually own account, smaller single centre studies, student research etc.

Appendix A - Local Clinical Audits

Local Clinical Audits April 2015 – March 2016 (Projects managed by the Clinical Quality Department)

Title/Topic	Gynaecology Record Keeping Audit 2014
Directorate/Specialty	O&G
Project Type	Audit
Completed	April 2015
Aims, Key Findings, Actions	**Main Aims:** To re-measure compliance with standards set out by NHSLA, CHKS and local guidelines, and to compare with previous audit findings **Findings:** Total number of standards measured = 70 50 standards (71%) Fully compliant 11 standards (16%) Moderate compliance 9 standards (13%) Low compliance. The percentage of standards fully compliant has increased (compared to previous audit) from 62% to 71%. The percentage of standards with either moderate or low compliance has decreased. **Key Recommendations:** • Increase awareness to improve documentation of review of test result • Nursing & Medical staff to be made aware of responsibilities in ensuring documentation complete/correct in relation to continuation sheets, NHS no, Hospital No and Consultant • Improve printing of names / use of stamps • Improve education to Medical staff to ensure completion of discharge letters, drugs on admission, tests and investigations

Title/Topic	Annual Health Records Audit General Medicine
Directorate/Specialty	General Medicine
Project Type	Audit
Completed	April 2015
Aims, Key Findings, Actions	**Main Aims:** To measure compliance with standards set out by NHSLA, CHKS and local guidelines, and to compare with previous audit findings. **Findings:** Only 9/66 (14%) standards were proved red while 9/66 (14%) were recorded as amber and 48 (72%) were evidenced as green. The results suggest a good evidence of compliance with the standards however significant improvement is required in following areas: Height and Weight measurements in physical examination Signing, naming, dating and timing of corrections Drugs on admission in discharge letter Accurate record of the changes made to the patients regular medications (on admission) in the discharge letter **Key Recommendations:** • To monitor and ensure that poor compliance areas are periodically checked and recorded • To monitor and review initial clerking notes • To monitor and review a sample EDL periodically with the team

Title/Topic	**Audit On The Management Of Post Exposure Prophylaxis Against Hiv Infection**
Directorate/Specialty	Gum
Project Type	Audit
Completed	April 2015
Aims, Key Findings, Actions	**Main Aims:** The practice of prescribing PEPSE in our department is compared with the recommended BHIVA national guidelines. **Findings:** Proportion of PEPSE patients having a baseline HIV test was 94% Proportion of PEPSE prescriptions administered within 72 hours of risk exposure was 90% Proportion of PEPSE prescriptions that fit within recommended indications was 78% Proportion of individuals completing 4-week course of PEPSE was 50% Proportion of individuals seeking PEPSE undergoing testing for STIs was 43% Proportion of individuals completing 12-week post-PEP HIV antibody/antigen test was 36% 22% of the patients did not require PEPSE as per guideline and it was prescribed as the patients have requsted. Initial consultation with patients requesting for PEPSE and giving evidenced based information to the patients to arrive at an informed decision should be encouraged Only half of all people who were given PEPSE have completed the course. A few took PEPSE until the results of the source patient was known. A few did not continue due to the side effects. Therefore it is recommended to prescribe for 5 days or 2 weeks at the initial visit to minimise the wastage By introducing a standardised proforma for the management of PEP would improve the standards of PEP provision **Key Recommendations:** • A standardised proforma for the management of people seeking for PEP provision to be introduced. • All the patients need to be screened for STIs. • All the patients to be seen and followed up by the HA. • All the patients are put in the HA diary and followed up according to the guidelines. • Initial prescription for a maximam of 2 weeks is advised and patients are encouraged to return in 2 weeks to monitor adherence and side effects. During the followup visit, further 2 weeks of PEP need to be given in the department.

Title/Topic	**Audit On LSVT**
Directorate/Specialty	Speech & Language Therapy
Project Type	Audit
Completed	May 2015
Aims, Key Findings, Actions	**Main Aims:** The main aim of this audit is to measure the change in loudness of the patient in producing "ah", functional phrases and in conversation, but also to discover the patient's perception of their change in speech. It hopes to identify if modified LSVT is a valuable therapy option or not. **Findings:** • Audit reveals a significant change in loudness post LSVT. The audit proves an increase in loudness in production of "ah", functional words and conversation in nearly all patients. The rationale of LSVT is to focus on loudness which will also prime the other modalities important in spoken communication eg articulation, intelligibilty, resonance, intonation. • The scores from the VHI show a pleasing improvement in patients' self rating. Only one person had shown no reduction in their disability rating, 3 people had a statistically non-significant reduction in their scores and 3 people had made statistically significant improvements in their perception of their speech on their lives. • The perceptual rating scale again showed a move in a positive direction. Patients generally felt more positive about their voices. • The general trend is that people feeling more positive after therapy. This is most noticeable when looking at "loudness" and "shakiness" which clearly correlate with the therapy. The therapy focuses on increasing volume which results in a stronger more fluent air flow and a subsequent reduction in "shakiness". • When looking at "hoarseness and scratchiness of voice", "monotone voice" & "slurring", there is some improvement, but perhaps the change is not as substantial as might be hoped for. These are changes that one might expect to folow in if loudness has improved. • Self rating of strain again has not shown a strong trend of reduced "strain". It is likely that the LSVT has led to an increased awareness of the amount of effort required to increase volume and clarity. With time it is expected that the amount of effort required would become more habitual. • Self ratings of "mumbling" and "others understanding" reveal a reduction in mumbling, and an increased perception of being understood by others. This has to be a particularly important positive result of therapy intervention. • Self rating of participation in conversations and starting conversations reveal a trend to increased participation in conversations and an increase in initiating conversations. When one considers disability, it is customary to measure participation in society and a reduction in dependence and passivity. This has to be positive if the (small number of) patients feel that they can initiate and join in with conversations more. • Overall the results are a good validation of using modified LSVT in order to increase loudness and therefore increase quality of voice and hence interaction and hence quality of life. The therapy programme relies on a therapist being able to offer one hour's therapy 3 times a week for 4 weeks for each patient to benefit. Unfortunately the adult Speech & Language Therapy service is not staffed adequately to be able to offer this therapy to adults with Parkinsons Disease. **Key Recommendations:** 1. SLT to seek support from relevant commissioners to offer funded modified LSVT therapy programmes to up to 10 patients with PD at Luton & Dunstable Hospital every year 2. SLT to present study to local PD voluntary groups to seek funding of modified LSVT therapy programmes to up to 10 patients with PD at L&D every year.

Title/Topic	**Survey Of Urinary Incontinence In Dme Wards** N = 114
Directorate/Specialty	DME
Project Type	Audit
Completed	June 2015
Aims, Key Findings, Actions	**Main aims:** • Identify incidence and prevalence of urinary Incontinence across DME wards • Develop service in order to improve practice **Findings:** • Survey shows that urinary incontinence is an important common health problem as evidenced by the incidence and prevalence in this group. • Both incidence and prevalence increases with age. • The study included 114 patients, 50% male, 50 % female. The report does show higher incidence/prevalence in female. • The incidence and prevalence of the incontinence problem varies from 17% to 63%. One has to remember that there are various terminologies used when you mention incontinence such as urge incontinence, stress incontinence, mixed incontinence, overflow incontinence (dry or wet), nocturia or it can be transient incontinence. Our study showed a variety of presentations in these different groups of incontinence. • In 88 out of 114 cases of incontinence the symptoms were present for months in 90% of the cases. • 68% of these group of patients did not ask for help from any healthcare professionals in our study. • For those who fulfilled exclusion criteria for this study due to critical illness or in altered mental status, the information of incontinence was gathered from the nurse and care giver and it showed that 14 out the 20 cases there was clear cut evidence of incontinence in those critically ill patients. • All these findings suggest that this is a major health problem in this group of patients. Incontinence is one of the geriatric giants and it affects the quality of life leading to increased medical morbidity, psychological morbidity (poor self esteem, social withdrawal, depression, sexual dysfunction). It also increases carer's burden and contributes to decisions to place individuals in a nursing home. • Urinary incontinence is also associated with mortality. The healthcare costs as per 2001 UK figure for incontinence is around £473 million. • Our current resource within our Trust is currently a one whole time equivalent continence advisor looking into bowel and bladder incontinence as well as looking into catheter care. There is also help with a few urology specialist nurses who deal with more complex issues along with some Urologists / urogynaecology clinician. • Currently there is no dedicated geriatrician with a special interest in incontinence. • Though it is counted as a routine screening by the nurses as well as the doctors, this does not happen on a regular basis due to resource constraints. • Incontinence obviously leads to mortality, morbidity, increased direct and indirect healthcare costs leading to a burden on our health and social care costs. • Also to remember in our territory, there is a community team employed by Primary Care Trust looking into incontinence. At this point I am certainly not aware that both the hospital and the community teams work in collaboration on this particular issue. Key Recommendations: • Training: Induction Jnr. Doctors to routinely ask all patients over 65 about incontinence • The newly devised continence assessment form to be completed by nurses/doctors and a copy sent to continence advisor. Any concerns to be:

	• a) Highlighted immediately to the clinician involved. b) Highlight to the continence advisor. c) Advise patients/carers to fill bladder diary. • Promote awareness of this problem to patients by providing leaflets/posters which are currently available from Age UK. • Improve awareness of this problem to the healthcare professionals, junior doctors and clinicians as well as nurses by regular teaching and training. The DME department already has got regular training arranged by the continence advisor. • Develop continence care pathway. • Identify clinical lead within existing DME resources. Set up a business case for multidisciplinary clinic involving urologists, continence advisor, and Geriatric consultant with special interest in incontinence.

Title/Topic	**End Of Life Care Cquin 2014/15** Third Phase N= 40
Directorate/Specialty	Corporate
Project Type	Audit
Completed	July 2015
Aims, Key Findings, Actions	**Main aims:** • Review current end of life care. • Review evidence of symptom assessment and control. • Assess the use of processes relevant to end of life care, i.e. DNACPR and PRP. • Examine support of dying patients and their family as revealed by conversations recorded in medical notes and other activities. **Findings:** 1. **To assess the care by looking at evidence of symptom assessment and control** • 88% of patients were identified as being in the last days/hours of life. • In 95% of cases there was evidence in the notes that a health care professional believed the patient to be dying in the last 3 days of life. • 28% of cases reviewed had documented evidence that patients complained of pain and of those, all (100%) had actions undertaken to resolve the symptoms. 91% noted the actions were effective. • 5% of patients had nausea and vomiting and action was taken in all cases with effectiveness of the intervention noted in all cases. • 33% of patients had breathlessness as a symptom. 85% had action taken to resolve the symptom and in 91% of cases effectiveness of action was noted. • 25% of patients were described as having terminal agitation, of which 90% had action taken to resolve it and 89% noted its effectiveness. • 15% of patients had noisy respiratory secretions, action was taken in all cases and 83% noted the effectiveness of the action. • In 83% of cases there was evidence that usual medications were reviewed when the patient was identified as dying. 2. **Assess the use of processes relevant to end of life care such as the DNACPR and PRP** • 93% of cases reviewed had a DNACPR and 75% of those had been discussed with the family. • 85% of patients had a Personal Resuscitation Plan and of those 44% were reviewed since it was initiated. • 7% of patients had an Advance Statement. 3. **Examine support of dying patients and their family as revealed by conversations recorded in medical notes and other activities** • In 15% of cases there was evidence the patient's preferred place of death was documented. In 28% of cases the patient's preferences and concerns were noted. No patients had an advanced decision to refuse treatment in place. • Advice was sought from the palliative care team in 23% of cases. Spiritual and/or religious wishes were discussed in 33% of cases. • In 83% of cases, there was documented evidence the patient/family's views were discussed. In 78% of cases, there was evidence the family had the plan of care explained and the patients' timescales were estimated in 68% of cases. The fact the patient was dying was discussed with family in 68% of cases. • Hospital facilities were only explained in 13% of cases. In 75% of cases the staff discussed the patients care with family on each of the last 3 days.

- Following the patient's death, 13% of cases indicated the death was certified by a Nurse and 43% of records indicated information leaflets were offered to the bereaved. In 60% of cases, bereavement support was offered to the family/next of kin.

Key recommendations:

- Continued education about the recognition of dying. This will be achieved in the education attached to rolling out the Individualised Care Plan for the Dying Patient. Also ward based coaching for medical staff.
- To continue educating both nursing and medical staff on the importance of prescribing for the 5 common symptoms for the dying patient when introducing the Individualised Care Plan for the Dying Patient. To also capture during ward based coaching sessions.
- To raise awareness when rolling out the Individualised Care Plan for the Dying Patient. At the same time introducing a spot check audit, to be lead by senior nursing staff. Discharge liaison and the Palliative Care team – including the site specific nurses. To nurture ongoing learning and improvement.
- To provide education on the importance of supporting famililies when an end of life event is evident. Learning will be indicated in the documentation of the Individualised Care Plan for the Dying Patient. Further inforced with spot check audits.
- To increase the evidence of DNACPR being discussed with the family or the next of kin. To be achieved through spot check audits and further education at the point of need.

Title/Topic	**Audit Of Fluid Balance Monitoring** N= 47
Directorate/Specialty	General Medicine
Project Type	Audit
Completed	July 2015
Aims, Key Findings, Actions	Main aims: The aim of this audit is to evaluate if fluid balance is well assessed in the Emergency Assessment Unit (EAU) at Luton and Dunstable University Hospital and if NICE guidelines are respected. Main objectives are: • To identify current practice • To measure current practice against best practice • To improve current practice **Findings:** • The audit identified a lack of fluid balance monitoring and completion of fluid balance charts when patients are admitted to EAU • A good result has been found with regards to recording vital parameters such as BP and HR, both reported in 100% of cases • The audit highlighted that staff often undermined the importance of recording hydration and fluid volume indicators, such as capillary refill, lying and standing blood pressure, JVP and oedema. According to NICE guidelines, it is important to report at least one of the following: Capillary Refill Time, skin turgor and lying and standing BP. Despite such requirement, in only 2% of patients this information was collected • Skin turgor was not recorded at all, even if 50% of patients were under 70 years of age • The presence or absence of oedema is also a requirement to evaluate, as it indicates a fluid retention in the body and a higher risk of fluid overload if intravenous therapy is not given appropriately. NICE guidelines recommend to record signs of oedema from lungs, ankle and sacral area. The latter was never specificately mentioned, but assumed to be included when in clinical notes is written "no signs of oedema". Ankle oedema was included or excluded in 45% of cases whereas the presence or absence of basal crackles was recorded in 81% of cases • Another sign of fluid overload is the JVP which together with oedema and age parameters, should play an important role in the fluid management, was recorded in less than 50% of cases • Despite the missing information regarding multiple aspects of fluid balance, over 2/3 of patients received fluids on admission, almost 1/6 received electrolites and 15% of patients received furosemide • Half of the patients had fluid charts completed • The audit identified what appears to be a lack of standardisation and monitoring of fluid balance. It seemed that staff concentrated more on respiratory and cardiac systems (HR, BP, basal crackles), paying less attention to the important role of fluid balance assessment **Key recommendations:** Discuss findings with nurses and junior doctors in order to increase awareness.

Title/Topic	
Directorate/Specialty	OMFS
Project Type	Patient Survey
Completed	August 2015
Aims, Key Findings, Actions	**Main Aims:** • Identify levels of patient satisfaction (surgical patients) within OMFS • Identify specific areas for improving patient experience **Findings:** • All patients, at the initial consultation, were given a clear and thorough explanation of what the procedure involved • 60% of patients were seen on time when they arrived for their surgical appointment. The remaining 40% felt they were not seen on time, of which 44% experienced a 10-20 minute delay and 56% experienced a 20-40 minute delay • All patients stated the procedure was explained to them when they were called into surgery • 98% of patients stated they signed a consent form • 89% of patients were asked about their medical history before the procedure began • The majority of patients (94%) scored 5 (excellent) when asked how confident they felt with their Surgeon and dental team. The remaining 6% scored 1 or 2 (poor/fairly poor) • The majority of patients (94%) scored 5 (excellent) when asked whether the dental team were sensitive to their needs throughout the procedure • 92% of patients scored 5 (excellent) when asked whether they felt they were treated with dignity and whether their privacy was respected • The majority of patients (94%) scored 5 (excellent) when asked whether they were given clear verbal and written post-operative instructions • 88% of patients scored 5 (excellent) when asked whether they were given appropriate contact details in case of any concerns or further queries regarding their surgery. 10% scored 1 (poor) • 92% of patients scored 5 (excellent) when asked how they would rate the care and treatment received on the day of surgery • All patients stated they would recommend the department to friends and family. **Key recommendations:** • Provide clear instructions (verbal & written) • Reduce background noise • Highlight emergency contact numbers • Start on time: both nurses & surgeons • Set up and ensure the room is ready for surgical cases as a priority • Inform patients of any delay • A new consent form must be signed for each procedure • Surgeon to update medical history at every surgery visit.

Title/Topic	**Paediatric Haematology Patient Satisfaction Survey** N = 11
Directorate/Specialty	Paediatrics
Project Type	Patient Survey
Completed	August 2015
Aims, Key Findings, Actions	**Main Aims:** • To identify levels of patient satisfaction amongst paediatric haematology patients • To ensure the service provided at the L&D meets the needs of families and to ensure problems are kept to a minimum • To identify further specific areas for improving patient experience and services to meet current demand **Findings:** • 46% of parents were happy with their child's appointment arrangements 'all the time'. 18% were happy with arrangements 'most of the time' and 36% were happy 'sometimes' • 46% of parents stated they get their appointment on time 'all the time'. Eighteen present stated they get their appointment on time 'most of the time' and the remaining 36% stated 'sometimes' • 18% of parents stated they are seen on the appointment time 'all of the time'. 27% stated 'most of the time', 27% stated 'sometimes' and the remaining 27% stated they are 'never' seen on their appointment time • The majority of parents (91%) stated staff were friendly and helpful either 'all the time' (36%) or 'most of the time' (55%) • The majority of parents (78%) stated their child's pre-transfusion bloods were done in Outpatients. • 18% of parents stated they were happy with the way the staff took their child's blood 'all the time'. 30% stated they were happy 'most of the time. The remaining 46% stated they were happy 'sometimes' • 37% of parents stated play distraction is used whilst their child is having bloods taken 'all the time'. 27% said this was the case 'most of the time'. 9% stated this was the case 'sometimes, and 18% stated this is 'never' the case • 37% of parents stated they understood what bloods were taken for which tests 'all the time'. 27% of parents stated this was the case 'most of the time'. 18% felt this was the case 'sometimes' and the remaining 18% felt they can 'never' understand which bloods are taken for which tests • 55% of parents felt the Doctors are friendly 'all the time'. 36% felt this is the case 'most of the time'. The remaining 9% of patients felt Doctors are friendly only 'sometimes'. • The majority of parents (82%) felt they could ask questions 'all the time' (46%) or 'most of the time' (36%). The remaining 18% felt they could ask questions 'sometimes' • The majority of parents (91%) felt the Doctors explained the treatment plan in a way they could understand 'all the time' (73%) or 'most of the time' (18%) • Thirty three percent of parents felt there is good communication regarding their child's latest treatment plan between the Doctors and their London Hospital 'all the time' in 33% of cases, 'most of the time' in 33% of cases, 'sometimes' in 22% of cases, and 'never' in 11% of cases • All parents (100%) would prefer to bring their child in on a Saturday instead of a week day • All parents felt staff are friendly either 'all the time' (64%) or 'most of the time' (36%) • Most parents felt their child's cannula is sited soon after their arrival either 'all the time' (18%) or 'most of the time' (73%) • 18% of parents felt their child's cannula is inserted skilfully 'all the time' in 18% of cases, 'most of the time' in 36% of cases and 'sometimes' in 46% of cases

- 46% of parents felt the play therapist is always available for their child's cannula procedure 'all the time'. 18% of parents felt this was the case 'most of the time, and 27% felt this was the case 'sometimes'
- 10% of parents felt their child finds the cannulation procedure frightening 'all the time'. 10% felt this was the case 'most of the time', and 70% of parents felt their child found the cannulation procedure frightening 'sometimes'
- When asked whether parents were happy with the time it takes for the blood transfusion bag to arrive via the porter, 18% felt they were happy 'all the time'; 36% felt happy most of the time; and 46% felt happy 'sometimes'
- When asked whether parents were happy with the time it takes to put up the blood transfusion, 9% felt they were happy 'all the time'; 46% felt happy 'most of the time'; 36% felt happy 'sometimes'; and 9% were 'never' happy with the time it takes
- When asked whether parents were satisfied with the transfusion procedure, 27% felt satisfied 'all of the time'; 55% felt satisfied 'most of the time'; 18% felt satisfied sometimes
- When asked whether parents felt there is enough play and distraction for their child, 37% felt this was the case 'all of the time'; 27% felt this was the case 'most of the time'; 18% felt this was the case 'sometimes'; and 9% felt this is 'never' the case
- When asked whether parents felt the staff talk to them and their child regarding problems they are having with their condition, 18% felt this was the case 'all the time'; 18% felt this was the case 'most of the time'; 46% felt this was the case 'sometimes'; and 18% felt this is 'never' the case
- 60% of parents felt they would like more psychological help for them and their child in dealing with their condition
- 27% of parents felt the service is flexible to allow for holidays away 'all the time'; 46% felt this was the case 'most of the time', and 27% felt the service is flexible 'sometimes'
- For parents with teenagers, 33% felt their teenager has enough information regarding their condition 'most of the time', 33% felt they had enough information 'sometimes' and 33% felt they 'never' have enough information
- All parents (100%) felt their child's opinion regarding their care is taken into consideration 'most of the time'
- 33% of parents felt they would like more teenage appropriate activities for their child 'all the time', 33% felt this the case 'sometimes', and 33% felt they would 'never' like more teenage appropriate activities for their child
- 67% of parents felt their teenager would like to know more information regarding their condition
- When asked whether parents felt they had adequate support in the community, 12% answered 'most of the time'; 38% answered 'sometimes'; and 50% answered 'never'
- Only 11% of children have a school care plan
- 71% of parents felt their child's school does not understand about their child's condition
- When asked whether parents felt they are given enough verbal and written information regarding their child's condition, 12% felt this is the case 'most of the time'; 63% felt this was the case 'sometimes'; and 25% felt they are 'never' given enough information regarding their child's condition
- The majority of parents (80%) are not aware of all the charities offering support
- None of the parents are aware of patient information days run by these charities

Key recommendations:

- Discuss blood bag collection delay with transfusion and Zoe Garside Transfusion specialist nurse
- Either Annabel Roxas or Karen Reep to be on duty for cannulation
- Discuss Community support and Community care plans for schools with service managers and Haematology team

Title/Topic	**Urinary Catheter Management Audit** N =
Directorate/Specialty	DME
Project Type	Clinical Audit
Completed	August 2015
Aims, Key Findings, Actions	**Main aims:** • Assess the practice of urinary catheter management in DME patients in Luton & Dunstable Hospital • To ensure correct and accurate documentation of catheterisation • To highlight areas requiring improvement **Areas of good practice** • 79% of patients with new catheter inserted had reasons for the insertion explained in casenotes. However, although positive, still room for improvement, aiming for 100% • More than 80% had a catheter identification sticker placed in the case notes • Almost 100% had catheter care plan at the bedside and the drainage bag was in the correct position • Safeguarding issues identified in 2 cases (pressure sores), accounting for 9% **Areas to improve** • Understand why increased number of catheters used in some wards compared to others in DME, for reaudit • Recording the place where catheter was inserted • Reason for insertion: 31% in DME patients had a LTC in situ done in the community; leaves 69% of patients new catheter done in LDH, reasons to be reviewed • 71% aseptic technique was documented. Aiming for 100% • 71% only had the residual urine volume recorded, should be 100% • Poor use of bladder scanning (only 8%) prior to catheter insertion –knowledge and costs barriers • Poor bowel assessment (33%) prior to insertion • No prostate assessment done in more than 90% of male patients prior to catheter insertion • Only 63% had a next change date on the bag • Different drainage bags are used across the Trust • About a fifth of cases did not have the catheter to remain in situ reviewed on a daily basis –high risk of infections • More than 90% of patients had no documentations that they consented to have the catheter inserted, nor of explanations of the procedure, or plans to remove the catheter and trial of TWOC • No documentation of continence issues being reviewed by the Therapists • No referrals to the Continence service in 96% of cases **Recommendations:** • Training, Induction Programmes & Teaching, Part of DME teaching program + Feed-back from attendees • Re-audit, including QIP • To involve trust wide Clinical Directors, as High Risk Practice (CQC) • To involve trust wide Clinical Directors, as High Risk Practice (CQC) • Business case for new scanners across the Trust • Trust awareness via Grand Round.

Title/Topic	**Audit On Urinary Incontinence Care At Luton And Dunstable Hospital** N = 64
Directorate/Specialty	DME
Project Type	Clinical Audit
Completed	August 2015
Aims, Key Findings, Actions	**Main aims:** • Assess the prevalence of urinary incontinence in elderly patients in the Department of Medicine for the Elderly (now Directorate, DME), in Luton & Dunstable Hospital • To ensure correct and accurate documentation of urinary incontinence • To evaluate if patients were appropriately assessed and managed • To highlight areas for improvement **Areas of Good Practice:** • Majority of patients with urinary incontinence (UI) in this audit were identified in ED (73%) and in the wards (11%), collaborative working with community staff is required to identify such patients within community • Identified 10% of terminally ill patients with UI and consequences of the UI • 79% of patients had their symptoms recorded in the notes • 82.5% of patients had their medication reviewed • Functional ability assessed in 93% • Cognition assessed in 86%, although aim is 100% • 100% had renal function checked **Areas to Improve:** • Although majority of patients with urinary incontinence (UI) in this audit were identified in ED (73%) and in the wards (11%), good as a Trust: needs to be identified in the community • Cognition assessed in 86%, aim is 100% • Most cases of UI were chronic or unknown length of time • Identified 34% of patients with acute UI who were not referred to continence services • Detailed history about symptoms of UI varies between 5% to 49%: aim 100% • Bladder diary not completed in any of patients • Only 65% of patients had their medical condition accessed and optimised • 7% of patients had an assessment of the impact of incontinence on quality of life. However this was not standardised assessment. None of patient's quality of life has been recorded by standard assessment (eg Kings Health Questionnaire) • Poor examination to look for the cause of urinary incontinence • Only 21% of patients had post void residual volume checked • 40% causes of urinary incontinence related to constipation. However only 17% of patients had digital rectal examination performed • 40% had recorded a treatment plan in the notes. However in 81% it only included a containment pads • 45% of patients had a catheter inserted with no reason for catheterisation and/or plan for removal of catheter documented in the notes • 76% had as consequences of urinary incontinence either UTI, Urosepsis or Pressure ulcers • No care plan or information on causes and treatment provided to patients • 88% of patients had no follow up • 95% not given any information how to cope with UI. Those 5% who had where given information on continence products only

Recommendations

- Training & Induction of staff
- Develop teaching program in collaboration with Bedfordshire Continence Service and MDT
- Re-audit and extend to entire Medicine, QIPs
- Involve new CDs
- Standardised documentation across the Trust (Bladder diaries, care plan etc)
- New clerking proforma for Quality of Life (QOL)
- Development of Trustwide Continence Service

Title/Topic	**Acute ENT Clinic Patient Satisfaction Survey** N = 88
Directorate/Specialty	ENT
Project Type	Patient Survey
Completed	September 2015
Aims, Key Findings, Actions	**Main Aims:** • To identify levels of patient satisfaction within the Acute ENT Clinic • To identify specific areas for improving patient experience **Findings:** • 60% of patients stated they were given a choice of appointment times • 48% of patients stated there was a delay in clinic. Of those, 40% were told how long they would have to wait. The remaining 60% were not told how long they would have to wait. • On a scale of 1 – 5 where 1 is poor and 5 is excellent, 54% of patients rated the cleanliness of the ENT department as 5, 38% rated it as 4, and 7% rated the cleanliness as 3 • 50% of patients scored 5(excellent) when asked if they were welcomed at reception. 24% scored 4, 10% of patients scored 3 (average) and the remaining scored either 2 or 1 (poor) • 85% of patients scored 5 (excellent) when asked if they were treated with dignity and respect. 8% scored 4, 2% scored 3 (average) and 5% scored 1 (poor) • The majority of patients (90%) scored 5 (excellent) or 4 (good) when asked if they were treated with sufficient privacy • Most patients (85%) felt staff were friendly and sensitive to their needs by scoring 5 (excellent). 10% of patients scored 4 and the remaining 6% scored either 2 or 1 (poor) • For those patients who contacted the department for any reason prior to the appointment, 74% scored 5 (excellent) with the service they received, 18% scored 4 • 94% of patients stated the staff treating/examining them introduced themselves • Most patients (86%) scored 5 (excellent) when asked if the Doctor explained the reason for any treatment or action in a way that they understood. 6% scored 4, 3% scored 3 (average) and the remaining 5% scored 1 (poor) • Most patients (86%) scored 5 (excellent) when asked if they received a sufficient answer to any questions. 7% scored 4, 1% scored 3 (average) and the remaining 6% scored 1 (poor) • The majority of patients (98%) felt they had enough time to discuss their health or medical problem with the Doctor • Almost all patients (99%) felt the Doctor listened to what they had to say • 98% of patients felt they had confidence and trust in the Doctor examining and treating them • Most patients (81%) scored 5 (excellent) when asked if they were involved as much as they wanted in decisions about their care/treatment. 10% scored 4 (good), 3% scored 3 (average) and the remaining 6% scored 1 (poor) • 72% of staff stated staff told them who to contact if they were worried about their condition/treatment after leaving the hospital • 80% of patients scored 5 (excellent) when asked how they would rate their overall care and treatment. 14% scored 4, 1% scored 3 (average). The remaining 5% scored either 1 or 2 (poor) • Most patients (70%) scored 5 (excellent) when asked how they felt their treatment was progressing. 19% scored 4 and the remaining 11% scored between 1-3. **Recommendations:** • Prompt start to clinic. Reduce delays where possible • Inform all patients of any delays of more than 20 minutes • Repeat survey in 9 months

Title/Topic	**General Paediatrics Internal Health Record Keeping Audit 2015** N = 30
Directorate/Specialty	Paediatrics
Project Type	Audit
Completed	September 2015
Aims, Key Findings, Actions	**Main Aims:** To re-measure compliance with standards set out by NHSLA, CHKS and local guidelines, and to compare with previous audit findings **Findings:** Total number of standards measured = 68 45 standards (66%) Fully compliant 5 standards (7%) High compliance 10 standards (15%) Moderate compliance 8 standards (12%) Low compliance. The percentage of standards fully compliant has increased from 51% to 66%. The percentage of standards with either moderate or low compliance has decreased, which indicate a general improvement since the previous audit in 2014 **Key Recommendations:** • Raise awareness of issues identified amongst Medical & Nursing staff and by presenting at CG meeting and discussing at Departmental meetings and Junior Doctor Inductions.

Title/Topic	**Pre-Operative Airway Assessment Audit** N = 74
Directorate/Specialty	Anaesthetics
Project Type	Audit
Completed	September 2015
Aims, Key Findings, Actions	**Main Aims:** • Establish current practice in assessment of pre-operative airway • Identify areas of good compliance • Identify areas of poor practice with a view to making improvements **Findings:** • 65% of cases were assessed by a Consultant, 28% by a Middle Grade Doctor and the remaining 7% by an SHO • 86% of cases were patients undergoing a maxillofacial procedure. The remaining 14% were patients undergoing an ENT procedure • Documentation of OSA was documented in 5% of cases. OSA documentation was not evident in 95% of cases • 21% of patients had a BMI of >35, the remaining 79% of patients had a BMI of <35 • The ASA grade was not evident in 3 cases. Of the remaining 71 cases, 48% of patients had an ASA grade of I, 32% had an ASA grade of II, 17% had an ASA grade of III and 3% of patients had an ASA grade of IV • There was no airway assessment undertaken in 16 cases (22%). Of the remaining 58 cases, 86% of patients had Mal scoring, 40% Jaw, 86% Dentures and 33% Neck • In 84% of cases the Assessor/Anaesthetist was the same. The remaining 16% of cases had a different Assessor/Anaesthetist • There was a predicted difficult airway assessed in 32% of cases • There was an actual incidence of difficult airway in 31% of cases • The airway assessment was documented to be complete in 22% of cases and incomplete in 78% of cases • Airway documentation was evident in 92% of cases **Key Recommendations:** • All patients to be assessed by the same Anaesthetist who performs the Anaesthesia • All patients to have a pre-operative airway assessment • All patients require full airway assessment documentation

Title/Topic	**Diagnosis and Initial Management of Transient Ischaemic Attack (TIA)** N = 20
Directorate/Specialty	DME
Project Type	Audit
Completed	September 2015
Aims, Key Findings, Actions	**Main Aims:** • Identify whether the Luton & Dunstable Hospital Trust are adhering to the NICE recommendations & Quality Standards for the diagnosis and initial management of TIA • Identify areas where compliance needs to be improved • Identify areas of good practice **Findings:** • There has been an improvement in risk satisfaction using ABCD2 score. • For patients attending A&E dept. various validated stroke scales have been used (NIHSS & mRS) • Written information to patients is provided very well (100%) • Initial Aspirin treatment is given in only 50% of cases and in this area to be improved. **Key recommendations:** • Present audit at A&E Departmental Meeting to raise this issue and educate A&E staff.

Title/Topic	**Feeding At Risk** N = 10
Directorate/Specialty	Therapies
Project Type	Audit
Completed	September 2015
Aims, Key Findings, Actions	**Main Aims:** • Investigate timeliness in clinical decision making for patients who present with dysphagia (swallowing problems) • Establishing who was involved in the decision making process • Establishing clarity of documented decisions • Establishing and documenting mental capacity in the medical notes • Establishing the need for a change in practice based on audit outcomes **Findings:** • 80% of the patients had a confirmed diagnosis of dementia and lacked capacity to make their own decisions on nutrition planning. Whilst the sample included mostly dementia patients, the FAR decision making process would be applicable for all patients who are unsafe for oral intake where alternative feeding is not appropriate. • There was evidence of rapid decision making for 60% of patients following consideration for FAR. (70% if include community patient) • There were 2 examples of MDT approach and best interest meeting - but inconsistent approach to decision making (opinions provided but lack of MDT discussion / meeting) • Inconsistent documentation of the FAR decision (40%) or discussion including outcome of mental capacity assessments in the medical notes • Delayed nutrition planning after FAR decision in 3 patients. (Reason for this may include SLT awaiting decision before providing recommendations / SLT unaware decision had been made / deterioration in patients condition .) • There were delays in identifying a swallowing problem following admission to hospital with a mean of 4 days recorded. Reasons for this could include patients who were admitted to hospital who remained *unresponsive* or were *not expected to survive due to the severity of their condition* but subsequently improved, those who developed swallowing problems *during* admission and *insufficient numbers of nurses trained to screen for swallowing problems on admission to hospital.* • The Speech and Language Therapy (SLT) team completed the initial specialist swallowing assessment within 2 days of receipt of referral for all patients, 60% of patients were assessed on the same day. **Key recommendations:** • To involve all stakeholders in a process to develop a clear Feeding at Risk Protocol and Pathway for the Luton and Dunstable Hospital • To improve communication across multi-disciplinary teams and family / carers with increased clarity and documentation in the FAR decision making process including documentation of capacity assessments when indicated. • To formalize and introduce Risk Feeding Guidelines in the acute and community settings and ensure ongoing care is handed over to the G.P , care home , palliative care teams , community matrons. • To improve the management of nutrition and hydration in advanced dementia and palliative care patients and help prevent unnecessary delays in decision making and re-admissions to hospital following discharge.

Title/Topic	**General Surgery Internal Health Record Keeping Audit 2015** N = 20
Directorate/Specialty	General Surgery
Project Type	Audit
Completed	October 2015
Aims, Key Findings, Actions	**Main Aims:** • To re-measure compliance with standards set out by NHSLA, CHKS and local guidelines, and to compare with previous audit findings from 2014. **Findings:** • Standards Fully Compliant: 43% of Standards • High Compliance: 7% of Standards • Moderate Compliance: 20% of Standards • Low Compliance: 30% of Standards • The percentage of standards fully compliant has slightly decreased from 45% to 43%. The percentage of standards with either moderate or low compliance has remained the same/increased, which indicate a general decline since the previous audit in 2014. **Key Recommendations:** • Decline in including all patient details (HN, NHS no, Name) on all records. This was often found on reverse of continuation sheets where label not fixed. Raise awareness of need to label both sides of continuation sheets as all pages are legal documents and scanned in as individual sides of A4. Provide a session on record keeping at FY1 induction. • Documentation of key aspects of history has declined (95 – 55%). Are Clinicians being rushed and unable to record these? Are they being recorded elsewhere if surgical proforma is hard to navigate? Does this need to be addressed in teaching or does proforma need to change? Audit to be presented and discussed in CGM. Provide a session on record keeping at FY1 induction. • Legibility, date, time, signature and name printing has declined. Are staff unaware that these must all be included in all entries? If clinicians are rushed, could staff be provided with a stamp which includes their names and details? Audit to be presented and discussed in CGM. Provide a session on record keeping at FY1 induction. • Poor completion of Yellow Boards. Encourage clinicians to write review on Yellow Board so that it is easily identified in notes. Audit to be presented and discussed in CGM. • Decline in evidence of involvement of patient / carers in decision making process. Is it just poorly recorded or are we not involving patients in this process? Perhaps patient / carer satisfaction questionnaires could be designed and reviewed to look specifically at this and teaching provided for clinicians highlighting the importance of documenting patient / carer involvement. Audit to be presented and discussed in CGM. Provide a session on record keeping at FY1 induction.

Title/Topic	**Faecal Incontinence Care** N = 50
Directorate/Specialty	DME
Project Type	Audit
Completed	October 2015
Aims, Key Findings, Actions	**Main Aims:** • Assess the prevalence of faecal incontinence in elderly patients in the Directorate of Medicine for the Elderly, in Luton & Dunstable Hospital • To ensure correct and accurate documentation of faecal incontinence • To evaluate if patients were appropriately assessed and managed • To highlight areas for improvement **Findings:** • Areas of Good Practice: • Cognition assessed in 80% of cases, there is room for improvement • Functional assessment done in 82% of cases • Patients with faecal loading • All patients identified with faecal loading had Bristol Stool Chart and were prescribed laxatives/enemas/suppositories • Bowel Management Care Plan is used and updated daily in 83% of cases • Areas to Improve: • Improve documentation on FI/constipation • Assessment of FI/constipation: needs to be comprehensive • Improve assessment of impact of FI on quality of life (QOL) • Use the Dementia CQUIN to improve cognitive assessment • Rectal examination only done in 52% of cases • Faecal loading only assessed in 52% of cases • Neurological examination only done in 20% of cases • Cause of FI was only identified in 30% of cases • Poor documentation on condition-specific interventions done • Improve diagnosis and treatment of comorbidities • Improve toileting advice and schedules • Improve medications and pharmacological interventions • Bowel training regimes • Dietician input • Advice on lifestyle • Treatment plan appear to include mostly containment devices • To provide a copy of their Bowel Management Care Plan to patients, as not done in 92% of cases • Only 50% of cases had documented evidence of a full discussion with the patient and carers/relatives of the causes and treatment of their bowel problem **Key recommendations:** • Training & Induction of staff • Develop teaching program in collaboration with Bedfordshire Continence Service and MDT • Re-audit and extend to entire Medicine, QIPs • Involve new CDs • Standardised documentation across the Trust • Adapted Kings Healthcare Questionnaire (QOL) • Development of Trustwide Continence Service.

Title/Topic	**Complex Regional Pain Syndrome Audit** N=10
Directorate/Specialty	Therapeutics
Project Type	Audit
Completed	November 2015
Aims, Key Findings, Actions	**Main Aims:** The main aim of the audit was to measure how compliant hand therapies were in following the new therapy guidelines, implementing therapeutic modalities and issuing patient hand-outs between the 1st August 2014 and the 1st August 2015 **Findings:** • Total of 13 standards: • 1 standard = fully compliant • 5 standards = moderate compliance • 7 standards = low compliance **Key Recommendations:** • Present audit findings at quarterly staff meeting in January 2016 • Further training on CRPS and review of guidelines with hand therapy team.

Title/Topic	**Trustwide Pain Survey 2015** N = 118
Directorate/Specialty	Corporate
Project Type	Patient Survey
Completed	November 2015
Aims, Key Findings, Actions	**Main Aims:** • Measure the efficacy of the action plans formulated within previous years • Inform the ongoing development of pain management care for all in-patients **Findings:** • Pain scores were recorded with every observation in 92% of cases. However, in 8% of cases, pain scores were not recorded at all, in the women's and children's directorate. In surgery and medicine 100% of patients had a pain score documented. The previous survey identified 71% of patients had their pain score assessed and documented on the observation chart with every observation. This was recorded intermittently in 26% of cases and not at all in 3% of cases. It is clear that the introduction of WardWare into the hospital has had a big impact on pain assessment documentation. However, the women's and children's directorate do not have ward ware due to specific needs for documentation in these areas. • 75% of patients surveyed reported they experienced pain during their admission. 83% experiencing pain described it as unbearable. The previous survey identified 86% of patients experienced pain during their admission. We know acute pain is usually associated with an underlying physiological (labour pain) or pathological (postoperative pain) process. Therefore it is understandable that many of our patients are admitted with a painful problem. It may be recurrent, with or without a background of ongoing chronic pain, (e.g. sickle cell disease, rheumatoid arthritis). Particularly after surgery, patients will be subjected to degrees of pain and we need to be able to assess this pain, commence pain strategies preoperatively if possible and implement strategies to minimise the pain so that the patient is able to deep breath, cough and mobilise comfortably postoperatively. • 91% of patients reported that staff asked if they were in pain compared to 92% in the previous survey. However, it is interesting as this differs as 100% of patients had a pain score documented on Ward Ware. This shows a small difference in patients self report and what is documented. • 75% of patients felt that staff were understanding and sympathetic about their pain. 12% of patients felt 'some staff' were understanding, whilst 13% of patients felt staff were not understanding about their pain. The previous survey identified 90% of patients felt hospital staff were understanding/sympathetic about their pain. Nine percent of patients felt hospital staff were not understanding / sympathetic about their pain. The audit shows a lesser amount of sympathy and understanding was offered within the medical directorate. • Suggestions were made by staff to reduce pain in 89% of cases, of which, painkillers was suggested in the majority (72%). The previous survey identified suggestions were made by staff to reduce pain in 95% of cases. Pain killers were suggested in 82% of cases, pain killers + changing position/walking/other was suggested in 16% of cases and changing position/walking/other was suggested in 2% of cases. 11% of patients felt nothing was suggested. This is an increase from the last audit which showed 5% of patients felt nothing was offered. We noticed that this again was within the medical directorate. This may be due to the nature of pain that is within the different directorate. In the medical directorate it may be that patients are suffering with long term conditions and chronic pain associated with this. The management of acute and chronic pain differs significantly. • There is a more proactive approach to acute pain to reduce complications of surgery and to improve outcome. In chronic pain medication can have limitations and it is often not appropriate to manage with medication alone. The patient may perceive this as the nurses or doctors not giving any suggestions for reducing their pain.

- 62% of patients reported that they received pain medication immediately after it was requested. 19% of patients reported they waited for an acceptable amount of time, and 19% felt they had to wait a long time to receive pain medication. The previous survey identified 82% of patients received pain medication straight away, 8% of patients waited an acceptable amount of time, 8% of patients had to wait a long time, and 2% of patients did not receive their pain medication. Patients are waiting longer for their analgesia than in 2012 audit. Over this time period tramadol (a opioid analgesia) has been changed schedule, and is now classed as a controlled drug in this trust. The implication being that it now needs to be checked by two nurses. We have also introduced EPMA which could affect the time it takes to administer the analgesia.
- There has been a slight decrease (from 71% to 66%) in the percentage of patients reporting that a nurse/doctor returned to check on their pain following pain relief. The worst performing area was the medical directorate. Only 43% of patients reported that the nurse or doctor re-evaluated the pain after an intervention was made. 50% said the nurse did not evaluate.
- 89% of patients felt nursing staff helped manage their pain. This has decreased from 2013 were 95% felt the staff did everything they could to control the pain. 11% did not compared to 6% in 2012. We need to develop a better understanding of the patients who reported that staff did not do everything they could to control the pain. A further audit is necessary enable a better understanding of why patients feel that nurses are not controlling their pain.
- 61% of patients experienced pain during the night, of which 70% felt it was managed appropriately. The previous survey identified 59% of patients experienced pain during the night, of which, 76% felt it was managed appropriately and 22% felt it was not managed appropriately. Patients do tend to experience more pain at night time. This is a common problem for anyone suffering with pain, this may be due to environment factors for example: sleeping in a different bed, noise levels, no distraction.
- 57% of patients felt overall their pain was managed very well, 17% felt it was managed reasonably well, 20% felt it could have been managed better and 6% felt it was not managed well at all. The previous survey identified 51% of patients felt their pain was managed very well overall, 30% felt it was managed reasonably well, 8% felt it could have been managed better, and 7% of patients felt their pain was managed not at all well. These are similar outcomes from the previous audit in 2012.

Key Recommendations:

- Continue training in importance of pain assessment and management.
- In the surgical division:
- Continue improving patient expectation and self-management of pain. Use mobilisation as an aid to improve pain control.
- Continue to work with enhanced recovery and MDT. To have guideline in place for orthopaedics.
- In the medical division:
- Present finding of this audit to medical directorate MDT.
- Complete further audit to focus on highlight issues – management of chronic pain in inpatients on medical wards.
- Have small group to action some change to enable ownership to the ward areas to improve assessment and management of patients in pain.
- Group to develop action plan.
- Pain service to continue and develop further workshops in medical areas.
- Work with pharmacy colleagues to explore changes to policy relating to tramadol and schedule 3 controlled drugs (inc oral morphine) with exemption of safe custody requirement.
- Highlight this to patients to ensure patients ask nursing staff for painkillers in a timely fashion. Include this in training.

Title/Topic	**ENT Internal Health Record Keeping Audit 2015** N = 30
Directorate/Specialty	ENT
Project Type	Audit
Completed	November 2015
Aims, Key Findings, Actions	**Main Aims:** • To measure compliance with standards set out by NHSLA, CHKS and local guidelines. **Findings:** • Standard fully compliant (100%): 64% of standards • High compliance (91-99%) : 17% of standards • Moderate compliance (75-90%): 10% of standards • Low compliance (<75%): 9% of standards Key Recommendations: Raise staff awareness at departmental meeting on following: 1. to ensure copy of A&E clerking with patient ID on form when accepting patients 2. to use sticky labels for notes – but three point identification should be sufficient name, DoB, hospital or nhs number 3. to check height and weight recorded in nursing documents on admission 4. to complete investigations & results section with nil if none carried out. Raise staff awareness at departmental meeting on following: 1. to request letter from referrer for every accepted referral 2. to use sticky labels for notes – but three point identification should be sufficient name, DoB, hospital or nhs number 3. to ensure all relevant sections of consent form are filled out at time of completion Re-Audit in 1 years time

Title/Topic	**Re-Audit Of Permeatal Transtympanic Myringoplasty** N = 13
Directorate/Specialty	ENT
Project Type	Audit
Completed	November 2015
Aims, Key Findings, Actions	**Main Aims:** To re-assess the outcome of Permeatal Transcanal Myringoplasty with tragal cartilage and perichondrium in terms of: Graft success rate Hearing improvement • To analyse post operative complications and follow up trends • To assess improvement in day case rates • To assess improvement in the use of endoscopes Findings: Permeatal Transtympanic Myringoplasty using tragal cartilage and perichondrium is a less invasive technique with equally good outcome in terms of graft take, improvement of hearing and low complication rate. • Ten (77%) patients were aged between 31 – 60 years • No patients had associated medical conditions i.e. DM and IHD • 46% of patients were male as compared with 54% females • No patients were indicated as smokers • All patients had central membrane perforation • Size of tympanic membrane perforation was 20 – 39% for 7 (54%) patients. The size for the remaining of patients was 40 – 59% (23% of patients) and 60- 79% (for 23% of patients) • 38% of patients had left sided tympanic membrane perforation. The remaining 62% of patients had right sided tympanic membrane perforation • Otitis media was the underlying cause for most (92%) of patients • Type of hearing loss was conductive in 69% patients • Average air conduction threshold was 31 – 45 for 7 (54%) patients pre-op and 5 (38%) patients post-op • Recurrent ear infection was the most frequent indication for surgery in all cases (100%) • Type 1 Tympanoplasty was carried out in 12 (92%) patients • No patients underwent revision operation • 54% of patients had overnight stay at hospital • Current operation technique was Microscopic, Permeatal Transtympanic in 39% of patients and Endoscopic Permeatal Transtympanic in 61% • Graft material was Tragal Cartillage and Perichondrium in all cases • Middle ear mucosa was normal in 92% cases • Condition of ossicles was intact in 92% of cases • First follow up was 2 weeks post op in 61% of cases • Second follow up was 5 -8 weeks in 38% of cases, 9-12 weeks in 31% of cases and 13-16 weeks in 23% of cases. One patient had their second follow up between 31-52 weeks • Third follow up ranged from 6 weeks to 44 weeks • Condition of graft was recorded as taken in 46% of cases and partial failure in 38% of cases • Post-operative audiology was carried out between 1-40 weeks with 50% of cases carried out between 11-20 weeks post-surgery

Key Recommendations:

- The audit identified inadequate/ inappropriate surgical instruments. Action to put forth a business case for acquiring Endoscopic Ear Surgery instruments
- Audit also identified unnecessary overnight stays. Action: All endoscopic myrigoplasty patients should be discharged home same day
- Erratic Post op follow up schedule also identified. Action: Follow ups should be as follows:
  First follow up = 2 weeks
  2nd follow up = 6 weeks
  3rd follow up = 6 months
- Erratic post op audiology schedule identified. Action: 1st audiogram = at 2nd follow up
- 2nd audiogram = at 6 month f/up

Title/Topic	**Safer Measurement & Administration Of Oral Liquid Medicines** N = 34
Directorate/Specialty	Corporate
Project Type	Audit
Completed	January 2016
Aims, Key Findings, Actions	Mains Aims: Assess practice in all clinical areas against the standards for oral liquid medicine administration to enable improvements in practice where necessary. The aim is to ensure that we provide safe care to our patients. **Objectives:** • Ensure availability of purple oral syringes in all areas where oral liquid medicines are administered • Ensure oral liquid medicines are prepared and administered using the appropriate device, e.g. graduated measuring cup, measuring spoon or by using a purple oral syringe if syringe administration is required **Findings:** • 32 of the 33 wards/clinical areas that are required to stock purple, oral liquid medicine syringes (97%) were compliant. One ward was out of stock. Action has been taken to immediately rectify by borrowing from another area until their supply arrives • The observational audit identified that staff in all clinical areas were compliant with best practice in administering oral liquid medicine using appropriate devices • The most frequently used devices to administer oral liquid medicines were graduated measuring cups (45%) and oral liquid syringes (44%). On 11% of occasions a combination of the two devices was, or would have been, used • No nurse used (or would have used) a measuring spoon **Key Recommendations:** • One clinical area did not have a stock or purple oral syringes at the time of the audit Action: Immediately stock that area by borrowing from another clinical area. Ensure that the ward has a system in place to ensure that the syringes are consistently stocked up. Matron for that area to do a spot check in one week. Add medicine pots and purple syringes to the checklists for the opening of contingency wards • Less than 100% of wards had a stock of purple oral syringes on the date of the audit and a Never Event related to a failure to keep a stock Action: Dedicate a Back to the Floor Friday Matron review to checking that practice and purple oral syringe stocks remain at 100%

Title/Topic	**Endoscopy Patient Satisfaction Survey** N = 98
Directorate/Specialty	Medicine
Project Type	Patient Survey
Completed	January 2016
Aims, Key Findings, Actions	**Main Aims:** • To collect information about patients' experiences during their hospital visit to the Endoscopy Unit • To identify patients' level of satisfaction within the Endoscopy Unit • To identify improvements in current practice and levels of patient satisfaction following the 2014 survey **Findings:** • The majority of patients (97%) rated the booking procedure as either excellent or good • 97% of patients felt the amount of information given by the Booking office was about right • 96% of patients felt the test was done quickly enough after being referred • 66% of patients were offered a choice of dates/times to have the test • Seven patients (7%) were asked to move their appointment, of which 2 patients were given an earlier date • 97% of patients felt they received enough information about what the test involved and 98% felt the information was easy to understand • The majority of patients (98%) found the instructions about the preparation clear to understand • The majority of patients (99%) rated the courtesy of staff in the Booking Office either very good or good • 15% of patients felt the Endoscopy unit was not clearly signposted • The majority of patients (98%) felt they were dealt with promptly and efficiently at the Endoscopy unit reception • Patients rated the courtesy of receptionists in the Endoscopy reception area as either very good (74%), good (23%) or satisfactory (3%) • 33% of patients stated there was a delay before they had their test and in a large number of these cases, no reason was given for the delay • 85% of staff rated the courtesy of the nurse preparing them for the test as either very good or good • The majority of patients (99%) felt the amount of information given to them by the Nurse preparing them for the test was either very good or good. The majority (98%) also felt the amount of information given was about right • Most patients (97%) felt they were given enough privacy when changing or being prepared for their procedure • 98% of patients felt their privacy/dignity was respected whilst on the Unit • 99% of patients stated the Endoscopist introduced themselves to them • The majority of patients (99%) rated the courtesy of the Endoscopist as with very good or good • 66% of patients felt the comfort level during the test was acceptable. 30% felt the comfort level was uncomfortable but acceptable. 2% felt the comfort level was unacceptably uncomfortable and 2% of patients could not remember • 29% of patients felt the test was more uncomfortable than they thought it would be • 44% of patients stated they were placed in a single sex area, 21% stated they were not placed in a single sex are and the remaining 35% did not know whether or not they were in a single sex area

- 77% of patients stated the results of the test were explained to them afterwards and 72% stated they were given written information about the results of their test
- For those patients who had a biopsy, 70% stated it was made clear to them how they could get the results
- 72% of patients stated they or their relative were given written information about the sedative
- 62% of patients were given a telephone number to ring if they needed advice after the test
- 61% of patients were advised about any necessary follow up appointments before leaving the department
- 73% of patients felt they would be extremely likely to recommend the Endoscopy Unit to friends and family. 25% felt they would be likely to recommend the unit

Key Recommendations:

- Admission nurses to keep patients and their relatives advised of any delays, and update white-board in reception area when appropriate
- Endoscopy staff to ensure patients are placed in single sex area. A question to be added to the questionnaire for the 2016 survey to ask if patients went straight from procedure room to seated recovery (which is unisex)

Title/Topic	**Audit Of Yellow Board Referrals Trauma & Orthopaedics** N = 181
Directorate/Specialty	T&O
Project Type	Audit
Completed	January 2016
Aims, Key Findings, Actions	**Main Aims:** • Evaluate the current use of Yellow Board referrals for Trauma & Orthopaedics • Identify areas for improvement, recommend suggestions and implement changes where necessary **Findings:** • One hundred and eighty eight patients were identified from ICE service provider • Out of 188 patients only 181 patients were included in the review; 7 were excluded due to inadequate request details (2), not on service provider (2), incorrect date on service provider (3) • Average age of patients was 47.5 years • 52% of patients were female, the remaining 48% were male • A large number of patients (35%) were referred from Geriatrics followed by Gastroenterology • 31% of referrer's were a CMT Grade, 26% were FY1's, 20% were FY2's, 10% were SpR's, 7% were Consultants and 6% were Staff Grade • The duration of symptoms was noted in 34% of cases. In 66% of cases the duration of symptoms was not documented • Previous treatment was only mentioned in 63 of the 181 cases • The referral was felt appropriate in 56% of cases and inappropriate in 44% of cases • 78% of referrals were urgent; the remaining 22% were routine referrals • 29% of patients were suitable for elective orthopaedic /fracture clinic. 71% of patients were felt not suitable • 42% of patients consumed 10 minutes of time; 58% consumed 30 minutes of time • Registrars feedback was evident in 51% of cases • The Orthopaedic Consultants name was noted in only 12% of cases • The Registrars full name was mentioned in 19% of cases **Key Recommendations:** • Improve documentation with clear precise information on the yellow board e.g. duration of symptoms and relevant past treatment given in order to prioritise the request. • Clear documentation for the reason of admission to the hospital. • Orthopaedic team reviewing patient to document in the medical notes of the Ortho consultant on call. • To save time, Orthopaedics Registrars to reply back to the queries on Yellow Board following trauma meetings. • Registrars completing the Yellow Board to document their surnames • Prepare a list of appropriate/inappropriate for the Yellow Board referral form Orthopaedic point of view

Title/Topic	**Trauma And Orthopaedics Internal Health Record Keeping Audit 2015** N = 20
Directorate/Specialty	T&O
Project Type	Audit
Completed	March 2016
Aims, Key Findings, Actions	**Main Aims:** • To re-measure compliance with standards set out by NHSLA, CHKS and local guidelines, and to compare with previous audit findings from 2013/2014 **Findings:** • 32% of standards fully compliant (100%) • 13% of standards with high compliance (91-99%) • 38% of standards categorised as moderate compliance (75-90%) • 17% of standards with low compliance (<75%) **Key Recommendations:** • Documentation at initial examination should be carefully documented, dated and timed. This should be applied to prescriptions and drug charts as well. Action: This will be discussed at the Clinical Governance Meeting and the teams will be notified separately by email in order to raise awareness • All Doctors to be notified of the need to accurately enter date and time of examination. The name should be clearly noted in block capitals under the initials with bleep numbers, where relevant. Height and weight measurements to be entered by admitting nurse. Electronic discharges to contain all relevant investigation results and drugs noted. Action: This will be discussed at the Clinical Governance Meeting and the teams will be notified separately by email in order to raise awareness

Title/Topic	**Out-Patient Hysteroscopy Clinic Patient Satisfaction Survey** N = 291
Directorate/Specialty	O&G
Project Type	Patient Survey
Completed	March 2016
Aims, Key Findings, Actions	**Mains Aims:** • To identify levels of patient satisfaction within the Outpatient Hysteroscopy Clinic • To identify any specific areas for improving patient experience **Findings:** • Just over half of respondents (51%) felt the clarity of information sent prior to the appointment was 'excellent'; 39% felt it was 'good'; 7% felt it was 'satisfactory'; 2% felt it was 'poor' and one patient (0.5%) felt it was 'very poor' • 51% of patients felt the speed of their appointment was 'excellent'; 35% felt it was 'good'; 10% felt it was 'satisfactory' and 4% felt it was 'poor/very poor' • 39% of patients felt the waiting time in the clinic was 'excellent'; 32% felt it was 'good'; 19% felt it was 'satisfactory'; 10% felt it was 'poor/very poor' • The majority of patients (88%) felt the dignity/respect shown by staff was 'excellent'; 11% felt it was 'good'; and 1% (4 patients) felt it was 'satisfactory' • The majority of patients (89%) felt the Doctors' professionalism was 'excellent'; 10% felt it was 'good'; and 1% felt it was 'satisfactory' • 62% of patients felt the clinic surroundings/waiting area was 'excellent'; 32% felt it was 'good'; 6% felt it was 'satisfactory'; and 1 patient felt it was poor • Almost three quarters of patients (74%) felt their general overall impression of the service was 'excellent'; 22% felt it was 'good'; 3% felt it was 'satisfactory'; and 1 patient felt it was 'poor' • Additional comments from patients were generally positive **Key Recommendations:** • Review clinic letter sent out to patients to address possible confusing information sent out prior to appointment • Review appointment times/length of appointment & review Clinic start/finish times to address waiting time issues

Title/Topic	**Trustwide Consent Survey and Documentation Review 2015** Number: Patient Survey = 75 Documentation Review = 124 Documentation Review (Ld/Dementia Patients) =30 Observational Audit = 20
Directorate/Specialty	Corporate
Project Type	Patient Survey & Audit
Completed	March 2016
Aims, Key Findings, Actions	**Main Aims:** • The main aim of this survey is: • To collect information about patients' experiences of providing consent for a procedure/ operation during their hospital visit/stay • Identify any gaps in documentation/completion of Consent Forms • To carry out an observational audit of staff obtaining patient consent from patients with Dementia and Learning Disabilities **Findings: Patient Survey:** • There has been an improvement in the percentage of patients (from 91% - 96%) reporting a member of staff explaining the nature and purpose of the procedure. • There has been a slight decrease in percentage of patients (from 100% - 95%) reporting a member of staff explaining the advantages of the procedure. • The 2014 audit demonstrated 90% of patients reported that disadvantages/risks were explained to them as part of the consent process. This year 92% of patients reported that disadvantages/risks were explained. • The number of patients who were advised of the type of anaesthetic/sedation which would be used during their procedure/operation has slightly decreased from 90% to 88%. • 95% of patients felt they were able to ask further questions before giving consent. The previous audit demonstrated 91% of patients felt they were able to ask further questions. • 71% of patients felt they were given enough time to consider the information provided before being asked to sign the consent form. This has dropped from 91% in the previous audit. • There has been a decline in the percentage of patients (71%) who felt they were given enough information (verbal/written) to help them make their decision. The previous audit demonstrated 91% of patients were given enough information. • 91% of patients felt they fully understood what the operation/procedure entailed. This has improved since the previous audit (82%). • 24% of patients felt they would have benefitted by having information provided in other formats. The previous audit demonstrated this was the case in 9% of cases. • 29% of patients reported they had not been given a copy of the signed consent form. The previous audit demonstrated just under half of the patients (46%) reported they had not been given a copy of the signed consent form. **Documentation of Consent Forms (Trustwide):** • No. of standards fully compliant = 16% • No. of standards with high compliance = 35% • No. of standards with moderate compliance = 6% • No. of standards with low compliance = 43%

Documentation of Consent Forms (LD/Dementia Pts):

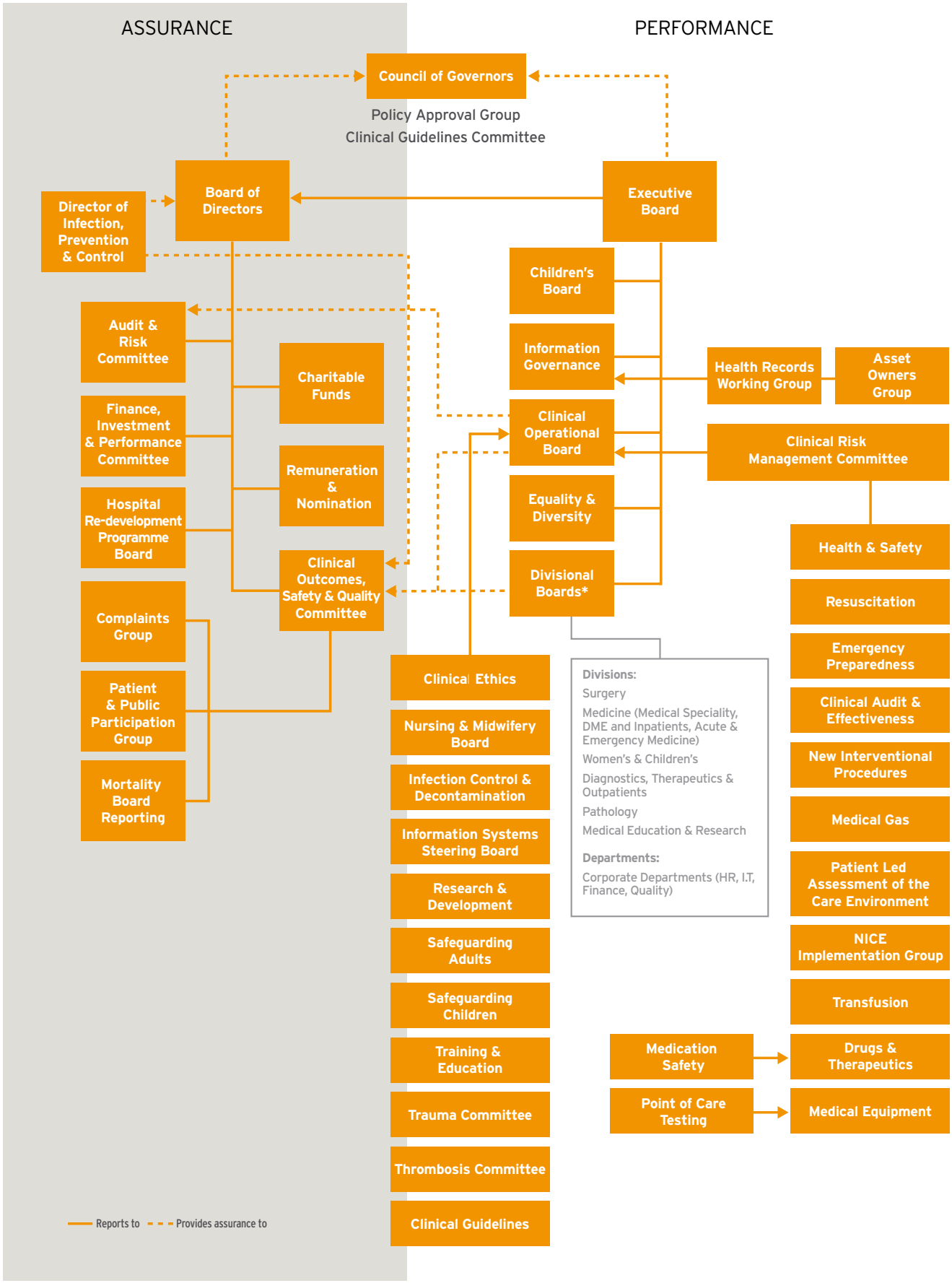
- No. of standards fully compliant = 55%
- No. of standards with high compliance = 19%
- No. of standards with moderate compliance = 6%
- No. of standards with low compliance = 19%

Key Recommendations:

- To undertake a more in depth patient experience survey to better understand the issues identified and develop a more comprehensive, focused action plan.
- To include assessment of capacity and best interest training in junior doctor induction, in respect of consent.
- Pre-operative checks must include a check that forms have been appropriately completed and appropriate action taken if not.
- Develop an audit programme to assess the robustness of mental capacity assessment.
- LD nurse to proactively monitor and provide support to the medical and nursing team caring for LD patients requiring consent to procedures
- Review and reinvigorate a more comprehensive training programme for clinical staff in consent
- Review and improve the consent documentation tool and re-audit in 6 months.
- Presentations at the following forums: Patient Safety Breakfast, Grand Round, Governance meetings, Dementia Strategy Group

Appendix B - Trust Committee Structure

Luton and Dunstable Hospital Governance and committee structure



* Divisional Board meeting include standard agenda items of Risk Management, Risk Registers, Incidents, Complaints and claims and information related to each of the relevant sub-committees of the Clinical Operational Board

Luton & Dunstable University Hospital
NHS Foundation Trust
Lewsey Road Luton LU4 0DZ
Telephone 01582 49 11 66
www.ldh.nhs.uk